Providence Health Plan

Providence Health Assurance

Healthcare Services Medical & Pharmacy Policy Alerts

Number 94

May 1, 2024

This is the May 1, 2024 issue of the Providence Health Plans, Providence Health Assurance and Providence Plan Partners, Medical and Pharmacy Policy Alert to our providers. The focus of this update is to communicate to providers' new or revised Medical or Pharmacy policy changes. The Health Plan has a standard process to review all Medical & Pharmacy Policies annually. Policies will be available for review on ProvLink and via the PHP website at: https://healthplans.providence.org/providers/provider-support/medical-policy-pharmacy-policy-and-provider-information/

The Provider Alert, Prior Authorization Requirements, and Medical policies are all available on ProvLink and through the link above.

NOTE: For Oregon Medicaid requests, services which do not require prior authorization will process against the Prioritized List. To determine which services require prior-authorization, please see the current PHP prior authorization list here.

****EXTERNAL PROVIDER REVIEW OPPORTUNITY****

PHP Medical Policy Committee is seeking feedback from providers to serve as clinical subject matter experts (SMEs) through the policy development and annual review processes. This review process allows providers to offer their expertise and discuss relevant research in their field that will be used to support how these policy decisions are made. This will allow providers an opportunity to offer valuable insight that will help shape policies that affect provider reimbursement and patient care.

If interested, please email us at PHPmedicalpolicyinquiry@providence.org with your name, specialty, and preferred email address.

Providence Health Plan

Providence Health Assurance

MEDICAL POLICY COMMITTEE

CODING & REIMBURSEMENT

Effective 7/1/2024

High-Cost Drugs

Providence Health Plan/Providence Health Assurance will begin reviewing drugs used in inpatient stays with a billed amount of $10,000 or more. In addition to medical appropriateness, we will review for average sales pricing (ASP) or average wholesale price (AWP) for each drug. If the billed amount exceeds 100% or more of ASP/AWP, the charge will be denied as a billing error. Facilities will need to provide justification for the excessive billed charge or rebill with standard pricing. ***Contract provisions (e.g., ultra-high-cost drugs) still apply and trump this review and associated denial.***

Claims Associated with Non-Covered Services

Providence Health Plan/Providence Health Assurance will begin denying claims that are associated with an already non-covered service. For example, if a member receives a not medically necessary surgical procedure, all associated services and claims related to that surgical procedure will also deny. Please see Appendix A below for a complete list of non-covered CPT codes that will be associated with this denial.

Leveling of Emergency Room Services

Providence Health Plan/Providence Health Assurance will begin to address appropriate levels of service based on the complexity of the condition rendered in the emergency department. When a physician or facility Emergency Department bills and evaluation & management level 4 (99284) or level 5 (99285) with a low acuity non-emergent (LANE) diagnosis code, The Plan will automatically reimburse the provider or facility at a level 3 (99283) reimbursement rate. A complete list of LANE diagnosis codes is included in Appendix B below.

Providence Health Plan

Providence Health Assurance

MEDICAL

COMPANY POLICIES

Effective 5/1/2024

Ablative Procedures to Treat Back and Neck Pain **MP21**	**Policy Updates:** • Added the following language to the "Policy Guidelines": ◦ "Repeat" procedures are procedures performed at the same location as a prior procedure that has occurred within the preceding two years. If more than 2 years have passed since the previous RFA and/or there is a question as to the source of the recurrent pain, then diagnostic procedures must be repeated. • Updated criterion II.B. clarifying that the pain relief should also be from the "prior" ablation but not necessarily the "initial" ablation. • Updated criterion I.C. to clarify that RFA is allowed in case of non-facet pathology. **Codes/PA:** No changes to coding/PA. **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.

Effective 6/1/2024

Balloon Dilation of the Sinuses or Eustachian Tubes **MP33**	**Policy Updates:** Removed criteria II.E. regarding the noncoverage of fungal disease for sinus dilation. **Codes/PA:** No changes. **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.

Thyroid Testing
 	
MP206
	Policy Updates: No change to criteria, continue to apply CMS NCD 190.22 for thyroid testing.
	Codes/PA: Update diagnosis code configuration based on Medicare quarterly laboratory NCD edit changes (source link).
	• ICD-10 codes **added to *pair to pay*** configuration:
	  ◦ D8984
	  ◦ I1A0

	○ R402A • There are no other changes to configuration: All other payable dx codes on the pair-to-pay set-up will remain allowed and claims submitted without a payable dx code will continue to deny NMN. **OHP:** OHP will follow the Company Policy above.

Effective 7/1/2024

Home Oxygen Equipment and Supplies **MP88**	**Policy Updates:** Changed denial language from investigational to not medically necessary. **Codes/PA:** No changes to codes or PA **OHP:** OHP will follow the Company Policy above.
Gene Expression Profile Testing for Breast Cancer **MP47**	**Policy Updates:** No recommended changes to criteria. **Codes/PA:** Changed denial for code 0045U from investigational to not medically necessary **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.
Orthognathic Surgery **MP160**	**Policy Updates:** • AllMed review recommended change to criteria. • Current criteria (criterion I.) requires that functional impairment be caused by deformity from birth, tumor, disease or injury. • Updated criterion I. to allow to follow AAOMS guidelines and require documentation of discrepancies associated with malocclusion. **Codes/PA:** No changes to codes or criteria. **OHP:** OHP will follow the Company Policy above
Ankle-Foot and Knee-Ankle-Foot Orthotics ***Formerly**: Ankle-Foot/Knee-Ankle-Foot Orthoses*	**Policy Updates:** • Rearranged criteria. • Added replacement criteria and criteria for multiple AFO or KAFOs for the same limb, as well as add criteria for orthotics requested only for recreational or leisure activities.

MP293	○ *While the above changes are consistent with criteria found in the general Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) policy, which are already used today, because these changes may be perceived as being more restrictive, we will provide 60-day notice for this updated policy draft, even though it is not intended to be more restrictive than what we are doing today.* • Title changed to remove "/" symbol. **Codes/PA:** No changes to codes or configuration (title changes only). **OHP:** OHP will follow the Company Policy above
Knee Orthotics (Functional Knee Braces) *Formerly: Knee Braces (Functional)* **MP91**	**Policy Updates:** • Updated title to more closely align current company policy naming convention with LCD title. • Added replacement criteria. (Replacement information was found in the "Policy Guidelines," but this update places it in the criteria table) • Added criteria for multiple knee orthotics for the same limb, as well as add criteria for orthotics requested for recreational or leisure activity purposes only. ○ *While the above changes are consistent with criteria found in the general Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) policy, which are already used today, because these changes may be perceived as being more restrictive, we will provide 60-day notice for this updated policy draft, even though it is not intended to be more restrictive than what we are doing today.* • Updated tables to new policy formatting. **Codes/PA:** No changes to codes or configuration. **OHP:** OHP will follow the Company Policy above
Genetic Testing for Hereditary Breast and Ovarian Cancer *Previously Genetic Testing: Hereditary Breast and Ovarian Cancer* **MP143**	**Policy Updates:** • Title updated • Updated cross referenced policy name changes. • Added Criterion V. for denial of repeat genetic testing for the same gene mutations. **Codes/PA:** None **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.

Protein Biomarker and Genetic Testing for the Prostate **MP96** *Formerly Prostate: Protein Biomarkers and Genetic Testing*	**Policy Updates:** • Title updated • Formatting updates • Updated to cross reference section with another policy name change. • Added criterion to deny repeat testing as NMN- criterion III **Codes/PA:** No changes **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.

MEDICARE POLICIES

Effective 6/1/2024

Respiratory Viral Panels **MP255**	**Policy Updates:** No changes to criteria. **Codes/PA:** Updated diagnosis code configuration to align with Noridian LCA changes.

Effective 7/1/2024

Ankle-Foot and Knee-Ankle-Foot Orthotics ***Formerly:*** *Ankle-Foot/Knee-Ankle-Foot Orthoses* **MP294**	**Policy Updates:** • Added criteria for multiple orthotics for the same limb, as well as add criteria for orthotics requested only for recreational or leisure activities. ○ *While the above changes are consistent with criteria found in the general Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) policy, which are already used today, because these changes may be perceived as being more restrictive, we will provide 60-day notice for this updated policy draft, even though it is not intended to be more restrictive than what we are doing today.*

	• Title changed to remove "/" symbol. **Codes/PA:** No changes to codes or configuration (title changes only).
Genetic and Molecular Testing **MP317**	**Policy Updates:** For cardiomyopathy testing (81439), added states and Medicare references not already included. All MACs now consider this code to be non-covered. No other criteria changes. **Codes/PA:** • Removed PA and added NMN denial to CPT 81439 • No other code or configuration changes with this interim update; however, Q3 2024 code set updates are expected and will be brought to MPC in the future.
Knee Orthotics (Functional Knee Braces) ***Formerly:*** *Knee Braces (Functional)* **MP297**	**Policy Updates:** • Updated title to more closely align current company policy naming convention with LCD title. • Added criteria for multiple knee orthotics for the same limb, as well as add criteria for orthotics requested for recreational or leisure activity purposes only. ○ *While the above changes are consistent with criteria found in the general Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) policy, which are already used today, because these changes may be perceived as being more restrictive, we will provide 60-day notice for this updated policy draft, even though it is not intended to be more restrictive than what we are doing today.* **Codes/PA:** No changes to codes or configuration.

Facility Routine Supplies and Services
 	
RP43
	Annual Review
	Recommendation: No changes to policy statement position.
	Reimbursement Methodology: No changes to reimbursement methodology.
	Relevant References/CMS Guidance:
	• Medicare Benefit Policy Manual, Chapter 1-Inpatient Hospital Services Covered Under Part A, §40.0-Supplies, Appliances, and Equipment
	• Medicare Benefit Policy Manual, Chapter 4-Part B Hospital, §230.2-Coding and Payment for Drug Administration
	• Medicare Claims Processing Manual, Chapter 20-Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), §210-CWF Crossover Editing for DMEPOS Claims During an Inpatient Stay
	• Medicare General Information, Eligibility, and Entitlement Manual
	  ○ Chapter 1-General Overview, §60.4-Statutory Obligations of Practitioners and Other Persons
	  ○ Chapter 4-Physician Certification and Recertification of Services, §10-Certification and Recertification by Physicians for Hospital Services
	  ○ Chapter 4-Physician Certification and Recertification of Services, §20-Certification for Hospital Services Covered by the Supplementary Medical Insurance Program
	  ○ Chapter 5-Definitions, §20-Hospital Defined
	• Provider Reimbursement Manual - Part 1, Chapter 22, §2202.4, §2202.6, §2202.8, §2203
	• MLN Matters® Number: MM8959. Implementing the Payment Policies Related to Patient Status from the CMS-1599-F
	• MLN Matters® Number: SE1333. Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims
	• Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
	• MLN Matters® Number: 1541573. Medicare DMEPOS Payments While Inpatient

Outpatient Hospital Services Rendered Prior to an Inpatient Admission **RP6**	**New Reimbursement policy** **Recommendation:** New reimbursement policy for all lines of business. This is not a change to current practices or workflow, but it is a formal policy to further support current processes. **Reimbursement Methodology:** No changes to reimbursement methodology. **Relevant References/CMS Guidance:** • Medicare Claims Processing Manual, Chapter 3-Inpatient Hospital Billing, §40.3 - Outpatient Services Treated as Inpatient Services, Subsections B and D. • Noridian web page for 3-Day Payment Window. • Social Security Act Section 1886 (d)(1)(B). Defines "non-subsection (d) hospitals." • Noridian web page for ACM Part A Questions and Answers - August 30, 2023. • MLN Matters SE20024. FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients. • Noridian web page for ACT Questions and Answers - September 28, 2022. • Noridian web page for Outpatient to Inpatient Status Change. • Centers for Medicare and Medicaid Services web page for Critical Access Hospitals.

VENDOR UPDATES

Effective 5/1/24

EviCore Physical and Occupational Therapy Clinical Guidelines	**Annual Update**
	Background: No changes that will impact the current clinical decision-making.
	Changes to current criteria:
	• **Definitions:**
	  ○ Editorial changes to definitions. Update of language to be more in line with WHO terminology as recommended by leading therapy associations.
	  ○ Added EviCore definitions of EIU and Medically Necessary.
	• **Criteria to determine medical necessity for skilled physical/occupational therapy care:**
	  ○ Added language to help clarify what information is needed for a request for review of medical need.
	  ○ Minor renumbering of actual criteria for Initiation of care. Which includes pulling out "meets definition of medically necessary care" as its own line item.
	  ○ Additional editorial modification to help clarify overall criteria.

	• **Rules. Coverage, Benefits and Mandates:**
	  ○ Editorial changes to help clarify reviews based on other national guidelines (Medicare/Medicaid) follow those respective guidelines or policies.
	• **Clinical considerations**:
	  ○ Minor editorial changes to help with clarity, added reference to include "reduction kit" as a new term for compression bandages.
	  ○ Further editorial changes.
	Codes/PA: No changes to codes or configuration.

Here's what's new from the following policy committees:

Pharmacy & Therapeutics (P&T) Committee

Oregon Region P&T Committee Meeting April 5, 2024

Go-Live Date: Saturday, June 01, 2024, unless otherwise noted

Special Announcement for GLP-1 receptor agonists:

For Commercial and Medicaid, the Prior Authorization policy has taken effect as of 5/1/24 for patients initiating therapy with a GLP-1 agent FDA approved for type 2 diabetes. For coverage, patient must have a confirmed diagnosis of type 2 diabetes and have one of the following:

1. Inadequate response to a medication containing metformin or insulin,
2. Intolerance or FDA labeled contraindication to metformin or insulin,
3. Patient has comorbid atherosclerotic cardiovascular disease (or is at high risk of atherosclerotic cardiovascular disease), heart failure, or chronic kidney disease

Note: This does not apply to those approved for weight management. Agents approved for weight management have different criteria and are only covered for groups that have the benefit for coverage of weight loss therapies,

Providence Health Plan

Providence Health Assurance

Table of Contents:

New Drugs and Combinations:

1. **Tirzepatide (Zepbound) Pen Inctr**:
   a. **Indication**: For the treatment of adults with:
      - obesity (BMI ≥30) or
      - overweight (BMI ≥27) with presence of at least one weight-related comorbidity

   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary for groups with weight loss benefit only	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	Tier 3 for groups with weight loss benefit only	N/A	N/A
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	N/A
Quantity Limit	2 mL per 28 days	2 mL per 28 days	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Anti-obesity GLP-1's semaglutide (Wegovy®), liraglutide (Saxenda®)			

   c. **Prior Authorization Criteria for Commercial**:

PA PROGRAM NAME	Weight Management Medications
MEDICATION NAME	Zepbound®
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
OFF-LABEL USES	None
EXCLUSION CRITERIA	• For tirzepatide (Zepbound), liraglutide (Saxenda), and semaglutide (Wegovy): Concurrent use with another GLP-1 receptor agonist for any indication

REQUIRED MEDICAL INFORMATION	For initiation of therapy, Zepbound®, Wegovy®, Saxenda®, or Qsymia® may be covered if all the following criteria must be met: a. Member's benefit provides coverage for weight management medications (Note that some benefits may have additional requirements, such as specific prescribing provider or program enrollment) b. For adults: i. Documentation of current height and weight (measured within the previous month) indicating one of the following: 1. Body mass index (BMI) of at least 30 2. BMI of at least 27 with the presence of at least one weight-related comorbidity (such as hypertension, type 2 diabetes mellitus/pre-diabetes, dyslipidemia, sleep apnea) c. For children: i. Documentation of current height and weight (measured within the previous month) indicating BMI is in the 95th percentile or greater, standardized for age and sex Notes: If race is known, lower BMI thresholds (usually reduced by 2.5) are used for people from South Asian, Chinese, other Asian, Middle Eastern, Black African, African-Caribbean, Native Hawaiian, Pacific Islanders, or American Indians/Alaska Natives family backgrounds. If race is not known, standard BMI parameters will be applied. For continuation of therapy, all the following criteria must be met: a. Patient's benefit provides coverage for weight management medications b. Patient has previous authorization for coverage with the plan or attestation from provider that coverage was provided through another health plan (new start to this plan). Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are NOT considered established on therapy. c. Patient achieved and maintained at least a 5% weight loss from baseline body weight while on the requested medication (documentation of baseline and most recent weight while on the medication are required)

d. **Prior Authorization Criteria for Medicaid**:

PA PROGRAM NAME	Weight Management Medications
MEDICATION NAME	Zepbound®,
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
OFF-LABEL USES	None
EXCLUSION CRITERIA	• For tirzepatide (Zepbound), liraglutide (Saxenda), and semaglutide (Wegovy): Concurrent use with another GLP-1 receptor agonist for any indication
REQUIRED MEDICAL INFORMATION	For initiation of therapy, Zepbound®, Wegovy®, Saxenda®, or Qsymia® may be covered if all the following criteria are met: a. Patient is less than 21 years of age b. Documentation of current height and weight (measured within the previous month) indicating BMI is in the 95th percentile or greater, standardized for age and sex

	Notes: If race is known, lower BMI thresholds (usually reduced by 2.5) are used for people from South Asian, Chinese, other Asian, Middle Eastern, Black African, African-Caribbean, Native Hawaiian, Pacific Islanders, or American Indians/Alaska Natives family backgrounds. If race is not known, standard BMI parameters will be applied. c. Documentation that the condition is of sufficient severity that it impacts the patient's health (such as quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc) For continuation of therapy, all the following criteria must be met (Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are NOT considered established on therapy): a. Patient is less than 21 years of age, b. Patient achieved and maintained at least a 5% weight loss from baseline body weight while on the requested medication

2. **Ritlecitinib tosylate (Litfulo) Capsule**:

a. **Indication**: For treatment of severe alopecia areata in patients 12 years of age and older.

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	
Quantity Limit	1 capsule/day	1 capsule/day	None
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: N/A			

c. **Prior Authorization Criteria for Commercial/Medicaid**:

PA PROGRAM NAME	Therapeutic Immunomodulators
MEDICATION NAME	Litfulo
EXCLUSION CRITERIA	N/A

REQUIRED MEDICAL INFORMATION	1. For all requests, the patient must have an FDA labeled indication for the requested agent or use to treat the indication is supported in drug compendia (such as the American Hospital Formulary Service-Drug Information (AHFS-DI) or Truven Health Analytics' DRUGDEX® System.) 2. The requested agent will not be given concurrently with another therapeutic immunomodulator agent 3. One of the following: a. For patients already *established* on the requested therapeutic immunomodulator: i. Documentation of response to therapy (such as slowing of disease progression or decrease in symptom severity and/or frequency). Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are NOT considered established on therapy. b. Patients not established on the requested therapeutic immunomodulator must meet ALL the following indication-specific criteria i. For severe alopecia areata (AA), baricitinib (Olumiant®) or ritlecitinib (Litfulo®) may be covered **if the member's benefit covers treatment for hair loss or alopecia areata** and all the following criteria are met: 1. Confirmation of severe disease, defined as current episode of AA lasting more than six months with at least 50% scalp hair loss at baseline 2. Other causes of hair loss have been ruled out (such as androgenetic alopecia) 3. For Medicaid, coverage for adults is unfunded. Coverage for children less than 21 years of age requires documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc.)
AGE RESTRICTIONS	Age must be appropriate based on FDA-approved indication
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, a dermatologist
COVERAGE DURATION	Authorization and reauthorization will be approved for one year

3. **Tenapanor hcl (Xphozah) Tablet**:

a. **Indication**: For treatment of high serum phosphorus in adults with chronic kidney disease (CKD) on dialysis as add-on therapy in patients who have an inadequate response to phosphate binders or who are intolerant of any dose of phosphate binder therapy.

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	N/A	N/A	N/A
Quantity Limit	60 tablets/30 days	60 tablets/30 days	60 tablets/30 days

* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).
Formulary Alternatives: calcium acetate oral capsule, lanthanum oral tablet, sevelamer carbonate oral tablet, sevelamer carbonate oral powder, sevelamer HCL oral tablet, Renvela® oral tablet, Renvela® oral powder, Fosrenol® oral tablet, Fosrenol® oral powder, Auryxia® oral tablet, Velphoro® oral tablet

c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part D:** N/A

4. **Eflornithine hcl (Iwilfin) Tablet**
   a. **Indication**: To reduce the risk of relapse in adult and pediatric patients with high-risk neuroblastoma (HRNB).
   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary	Formulary	Part D: Formulary Part B: N/A
Tier**	Tier 6 - Non-Preferred Specialty	N/A	Specialty
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: N/A			

   c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Oral Anti-Cancer Medications Policy
   d. **Prior Authorization Criteria for Medicare Part D**: Added to the Anti-Cancer Agents Policy

5. **Nirogacestat hydrobromide (Ogsiveo) Tablet**
   a. **Indication**: For the treatment of adult patients with progressing desmoid tumors (DTs) who require systemic treatment.
   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary	Formulary	Part D: Formulary

			Part B: N/A
Tier**	Tier 6 - Non-Preferred Specialty	N/A	Specialty
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: N/A			

a. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Oral Anti-Cancer Medications Policy
b. **Prior Authorization Criteria for Medicare Part D**: Added to the Anti-Cancer Agents Policy

6. **Cipaglucosidase alfa-atga (Pombiliti) Vial**
   a. **Indication**: For the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40 kg and who are not improving on their current enzyme replacement therapy (ERT).
   b. **Decision**:

	Commercial	**Medicaid**	**Medicare**
Formulary Status*	Medical	Medical	Part D: Non-formulary Part B: Medical
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	None	None	None
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Lumizyme, Nexviazyme			

c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part B**:

PA PROGRAM NAME	Enzyme Replacement Therapy
MEDICATION NAME	cipaglucosidase alfa-atga vial (Pombiliti®)
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
OFF-LABEL USES	None
EXCLUSION CRITERIA	N/A
REQUIRED MEDICAL INFORMATION	For initiation of therapy (new starts to therapy) all the following criteria must be met: 1. Documentation of FDA-labeled indication (See Appendix 1) for the requested product 2. Dosing is within FDA-labeled guidelines (See Appendix 1). 3. For cipaglucosidase alfa-atga vial (Pombiliti®) only, the following additional criteria must be met: a. Documentation of baseline percent-predicted forced vital capacity (FVC) of 30% or higher than the predicted value for healthy adults b. Documentation of baseline 6-minute walk test (6MWT) of 75 meters or greater Note: If request is for a non-FDA approved dose, medical rational must be submitted in support of therapy with a higher dose for the intended diagnosis such as high-quality peer reviewed literature, accepted compendia or evidence-based practice guidelines and exceptions will be considered on a case-by-case basis. For patients currently established on the requested therapy, all the following criteria must be met. Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are NOT considered established on therapy. 1. Documentation of successful response to therapy (e.g., disease stability or improvement in symptoms). 2. Dosing is within FDA-labeled guidelines Note: If request is for a non-FDA approved dose, medical rational must be submitted in support of therapy with a higher dose for the intended diagnosis (such as high-quality peer reviewed literature, accepted compendia or evidence-based practice guidelines) and exceptions will be considered on a case-by-case basis. QUANTITY LIMIT: Initial dose approval will be based on patient's current weight (See Appendix 1). Increases in dose will require new authorization with patient's weight and relevant chart notes *Other drug's drug-specific criteria not included*

7. **Motixafortide acetate (Aphexda) Vial**
   a. **Indication**: Used in combination with filgrastim (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with multiple myeloma.
   b. **Decision**:

	Commercial	Medicaid	Medicare

Formulary Status*	Medical	Medical	Part D: Non-formulary Part B: Medical
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	None	None	None
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: plerixafor (Mozobil®)			

c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part B**:

PA PROGRAM NAME	INJECTABLE ANTI-CANCER MEDICATIONS
MEDICATION NAME	APHEXDA SUBCUTANEOUS RECON SOLN 62 MG
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
OFF-LABEL USES	None
EXCLUSION CRITERIA	None
REQUIRED MEDICAL INFORMATION	For initial authorization: 1. Use must be for an FDA approved indication or indication supported by National Comprehensive Cancer Network guidelines with recommendation 2A or higher 2. For Aphexda: Dosing is within FDA-labeled guidelines
AGE RESTRICTIONS	N/A
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, an oncologist
COVERAGE DURATION	For Aphexda: Initial authorization will be approved for three months. No reauthorization; must meet initial authorization criteria.

8. **Bimekizumab-bkzx (Bimzelx) Auto Injct - Syringe**

a. **Indication**: For the treatment of adults with moderate to severe plaque psoriasis (PsO).

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	N/A	N/A	N/A

Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	N/A
Quantity Limit	2 syringes (320mg) /56 days	2 syringes (320mg) /56 days	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Adalimumab, Enbrel®, Cosentyx®, Stelara®, Tremfya®, Skyrizi®			

c. **Prior Authorization Criteria for Commercial**:

PA PROGRAM NAME	Therapeutic Immunomodulators
MEDICATION NAME	Bimekizumab (Bimzelx)
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
OFF-LABEL USES	N/A
EXCLUSION CRITERIA	N/A
REQUIRED MEDICAL INFORMATION	1. For all requests, the patient must have an FDA labeled indication for the requested agent or use to treat the indication is supported in drug compendia (such as the American Hospital Formulary Service-Drug Information (AHFS-DI) or Truven Health Analytics' DRUGDEX® System.) Exception: biosimilar products may be covered for all FDA-approved indications that the innovator product has been granted 2. The requested agent will not be given concurrently with another therapeutic immunomodulator agent 3. For patients already established on the requested therapeutic immunomodulator: a. Documentation of response to therapy (such as slowing of disease progression or decrease in symptom severity and/or frequency). 4. Patients not established on the requested therapeutic immunomodulator must meet ALL the following indication-specific criteria (note: if indication is not listed below, the requested drug may be cove red if it is an FDA approved indication for the requested drug): a. For moderate to severe plaque psoriasis, all the following criteria (i and ii) must be met: i. Documentation of trial and failure (after at least three months of therapy), intolerance, or contraindication to at least one of the following conventional therapies: methotrexate, tazarotene, topical corticosteroids, calcitriol, coal tar products, anthralin, calcipotriene, acitretin, cyclosporine, methoxsalen, tacrolimus, pimecrolimus, or phototherapy ii. Ixekizumab (Taltz®), brodalumab (Siliq®), and deucravacitinib (Sotyktu®) and bimekizumab (Bimzelx®) require documentation of trial and failure (after at least

	three months of therapy), intolerance, or contraindication to **three** of the following preferred agents: 1) preferred adalimumab product 2) apremilast (Otezla®) 3) etanercept (Enbrel®) 4) secukinumab (Cosentyx®) 5) ustekinumab (Stelara®) 6) gulselkumab (Tremfya®) 7) risankizumab-rzaa (Skyrizi®)

d. **Prior Authorization Criteria for Medicare Part D**: Added to Therapeutic Immunomodulators (TIMs) Policy - Medicaid

9. **Daprodustat (Jesduvroq) Tablet**

a. **Indication**: For the treatment of anemia due to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least four months.

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary	Formulary	Part D: Non-formulary Part B: Medical
Tier**	Tier 6 - Non-Preferred Specialty	N/A	N/A
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Aranesp, Epogen/Procrit/Retacrit/Mircera			

c. **Prior Authorization Criteria for Commercial/Medicaid**:

PA PROGRAM NAME	Jesduvroq®
MEDICATION NAME	Jesduvroq®
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
OFF-LABEL USES	N/A
EXCLUSION CRITERIA	• Concomitant use of strong CYP2C8 inhibitors (such as gemfibrozil) • Patients with uncontrolled hypertension

REQUIRED MEDICAL INFORMATION	For initial authorization, all the following must be met: 1. Documentation of anemia due to chronic kidney disease (CKD) 2. Documentation that the patient has received dialysis for at least four months. 3. Adequate iron stores as indicated by current (within the last three months) serum ferritin level greater than or equal to 100 mcg/L or serum transferrin saturation greater than or equal to 20% 4. Documentation is patient is hyporesponsive to erythropoiesis-stimulating agent therapy after at least four (4) months of therapy For reauthorization, all the following must be met: 1. Documentation of anemia due to CKD 2. Documentation the patient has experienced a therapeutic response, defined by an increase in hemoglobin from baseline
AGE RESTRICTIONS	May be approved for patients aged 18 and older.
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, a nephrologist.
COVERAGE DURATION	Authorization will be approved for six months. Reauthorization will be approved for 12 months.

10. **Colchicine (Lodoco) Tablet**

a. **Indication**: To reduce the risk of myocardial infarction (MI), stroke, coronary revascularization, and cardiovascular death in adult patients with established atherosclerotic disease or with multiple risk factors for cardiovascular disease.

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary	Formulary	Part D: Formulary Part B: N/A
Tier**	Tier 4	N/A	Non-preferred Drug
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit			
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives:			

c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part D**:

PA PROGRAM NAME	Lodoco
MEDICATION NAME	Colchicine tablet
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
EXCLUSION CRITERIA	• Concurrent use of strong CYP3A4 or P-glycoprotein inhibitors • Renal failure (CrCl less than 15 mL/min) • Severe hepatic impairment • Pre-existing blood dyscrasias
REQUIRED MEDICAL INFORMATION	For initial authorization, patient must meet all of the following criteria: 1. Diagnosis of clinical Atherosclerotic Cardiovascular Disease (ASCVD) or previous cardiovascular (CV) event 2. Documentation that patient is receiving maximally tolerated statin therapy or, if statin intolerant, other lipid-lowering therapy unless contraindicated or not tolerated 3. Documentation of blood pressure less than 130/80 or that patient is optimized on standard of care medications for high blood pressure unless contraindicated or not tolerated 4. Documentation that patient is on aspirin therapy for secondary ASCVD prevention unless contraindicated or not tolerated
AGE RESTRICTIONS	N/A
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, a cardiologist
COVERAGE DURATION	Authorization will be approved until no longer eligible with the plan, subject to formulary and/or benefit changes

11. **Somatrogon-ghla (Ngenla) Pen Injctr**

a. **Indication**: For treatment of pediatric patients aged 3 years and older who have growth failure due to inadequate secretion of endogenous growth hormone.

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	N/A
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements.			

** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).
Formulary Alternatives: Genotropin®, Norditropin®, Omnitrope®

c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Human Growth Hormones Policy

12. **Palovarotene (Sohonos) Capsule**

a. **Indication**: To reduce the volume of new heterotopic ossification (HO) in adults and children aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressiva (FOP).

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	N/A
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: None			

c. **Prior Authorization Criteria for Commercial/Medicaid**:

PA PROGRAM NAME	Medications for rare indications
MEDICATION NAME	Palovarotene capsule (Sohonos®)
EXCLUSION CRITERIA	N/A
REQUIRED MEDICAL INFORMATION	For initial authorization, all the following must be met: 1. Confirmation of FDA-labeled indication (appropriate lab values and/or genetic tests must be submitted – (See Table 1 and Table 2) a. For Sohonos®: Diagnosis of fibrodysplasia ossificans progressiva with presence of a R206H *ACVR1* (activin A type 1 receptor) mutation confirmed by genetic testing

	2. Dosing is within FDA-labeled guidelines OR documentation has been submitted in support of therapy with a higher dose for the intended diagnosis such as high-quality peer reviewed literature, guidelines, other clinical information For reauthorization, all the following must be met: 1. Documentation of benefit of therapy as evidence by improvement in symptoms, disease stabilization or lack of decline compared to the natural disease progression a. For palovarotene (Sohonos®) only, documentation of one of the following must be met: i. Reduction in the volume of new heterotopic ossification as confirmed by radiographic assessment such as X-ray, computed tomography (CT), magnetic resonance imaging (MRI) ii. Reduction in the rate of flare-ups iii. Stabilization or improvement in one of the following: Cumulative Analogue Joint Involvement Scale (CAJIS), fibrodysplasia ossificans progressiva (FOP) – Physical Function Questionnaire (FOP-PFQ) 2. Dosing is within FDA-labeled guidelines OR documentation has been submitted in support of therapy with a higher dose for the intended diagnosis such as high-quality peer reviewed literature, guidelines, other clinical information
COVERAGE DURATION	For palovarotene (Sohonos®), initial authorization and reauthorization will be approved for one year. For all other medications, initial authorization will be approved for one year and reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes.

d. **Prior Authorization Criteria for Medicare Part D**: N/A

13. **Vonoprazan fumarate (Voquezna) Tablet**

a. **Indication**: For the treatment of Helicobacter pylori(HP) infection in adults.

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	N/A	N/A	N/A
Quantity Limit	For *H.pylori*: 1 pack/14 days	For *H.pylori*: 1 pack/14 days	For *H.pylori*: 1 pack/14 days
* Recommendations for placement may differ between lines of business due to regulatory requirements.			

** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).
Formulary Alternatives: Erosive esophagitis: esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole H. Pylori: amoxicillin-clarithromycin-lansoprazole oral combo pack 500-500-30mg; Omeclamox-Pak oral combo pack 20-500-500mg; Talicia oral capsule 10-250-12.5mg; bismuth subcitrate-metronidazole-tetracycline oral capsule 140-125-125mg; Pylera oral capsule 140-125-125mg

14. **Adamts13, recombinant-krhn (Adzynma) Kit**

a. **Indication**: For prophylactic or on demand treatment of adult and pediatric patients with congenital thrombotic thrombocytopenic purpura (cTTP).

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Medical	Medical	Part D: Non-formulary Part B: Medical
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: N/A for pharmacy benefit; plasma based therapies for medial benefit			

c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part B**:

PA PROGRAM NAME	Enzyme Replacement Therapy
MEDICATION NAME	ADAMTS13, recombinant-krhn (Adzynma®)
PRESCRIBER RESTRICTIONS	Must be prescribed by or in consultation with a Hepatologist, Endocrinologist, Medical Geneticist, Cardiologist, Pulmonologist, Hematologist, Oncologist or Bone and Mineral specialist

15. **Efgartigimod alfa-hyaluronidase-qvfc (Vyvgart Hytrulo) Vial**

a. **Indication**: For the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Medical	Medical	Part D: Non-formulary Part B: Medical
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Vyvgart®, Soliris®, Ultomiris®			

c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part B**: Added to the FcRn Antagonists Policies

New Indications:

Therapies with Prior Authorization Policies (Non-oncology)

1. **Cresemba** (isavuconazonium)
    a. Previous Indication(s):
        a. Treatment of
            1. Invasive aspergillosis
            2. Mucormycosis
    b. New indication approved 12/08/2023:
        a. Treatment of invasive aspergillosis and mucormycosis:
            1. Injection: adults and pediatric patients 1 year of age and older
            2. Capsule: adults and pediatric patients 6 years of age and older who weigh 16 kilograms and greater
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Update policy with new indication.

2. **Adbry** (tralokinumab)
    a. Previous Indication(s):
        a. For the treatment of moderate-to-severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable

b. New indication approved 12/14/2023:
    a. For the treatment of moderate-to-severe atopic dermatitis in patients aged **12 years and older** whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable
c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Update policy with new indication and age restriction.

Prior Authorization Criteria for **Commercial/Medicaid**:

PA PROGRAM NAME	Adbry
MEDICATION NAME	Adbry
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
AGE RESTRICTIONS	The patient's age must be within FDA labeling for the requested indication

3. **Zoryve Foam** (roflumilast)
    a. Previous Indication(s):
        a. N/A
    b. New indication approved 12/15/2023:
        a. Treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Update policy with new indication and age restriction.

Prior Authorization Criteria for **Commercial/Medicaid**:

PA PROGRAM NAME	Vtama, Zoryve
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
AGE RESTRICTIONS	Zoryve® Foam - Approved for patients 9 years and older
REQUIRED MEDICAL INFORMATION	For Commercial initial authorization: A. Plaque psoriasis: Vtama cream or Zoryve cream may be covered when the following criteria are met: 1. Inadequate response to a sufficient trial (defined as two weeks or more of consistent use) of at least one of the following combinations: a) A high to ultra-high potency topical corticosteroid (such as betamethasone dipropionate 0.05% cream or ointment, triamcinolone 0.5%, clobetasol 0.05%) used concurrently with a generic topical calcipotriene product, OR b) A generic calcipotriene/betamethasone combination product, OR c) A high to ultra-high potency topical corticosteroid (such as betamethasone dipropionate 0.05% cream or ointment, triamcinolone 0.5%, clobetasol 0.05%) used concurrently with a generic tazarotene 0.1% cream B. Seborrheic dermatitis: Zoryve foam may be covered when the following criteria are met: 1. Inadequate response to a sufficient trial (defined as two weeks or more of consistent use) of at least one of the following combinations:

	a) Topical antifungal (such as ketoconazole 2%, econazole 1%, oxiconazole 1%, or ciclopirox 0.77%) used concurrently with a high-potency topical corticosteroid (moderate to severe scalp condition) or low-potency topical corticosteroid (non-scalp/face condition), OR b) Topical antifungal (such as ketoconazole 2%, econazole 1%, oxiconazole 1%, or ciclopirox 0.77%) used concurrently with a topical calcineurin inhibitor (such as tacrolimus 0.1%)

4. **Tarpeyo** (budesonide)
    a. Previous Indication(s):
        a. Reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g
    b. New indication approved 12/20/2023:
        a. Reduce the loss of kidney function in adults with primary immunoglobulin A nephropathy (IgAN) who are at risk for disease progression
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Update policy with new indication. Policy under review for April P&T.

5. **Yuflyma** (adalimumab-AATY)
    a. Previous Indication(s):
        a. Rheumatoid Arthritis
        b. Juvenile Idiopathic Arthritis
        c. Psoriatic Arthritis
        d. Ankylosing Spondylitis
        e. Crohn's Disease
        f. Ulcerative Colitis
        g. Plaque Psoriasis
        h. Hidradenitis Suppurativa
    b. New indication approved 12/22/2023:
        a. Uveitis
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Update policy with new indication.

6. **Dupixent** (dupilumab)
    a. Previous Indication(s):
        a. Eosinophilic Esophagitis
            1. For the treatment of adult and pediatric patients aged 12 years and older, weighing at least 40 kg, with eosinophilic esophagitis (EoE)
    b. New indication approved 1/25/2024:
        a. Eosinophilic Esophagitis
            1. For the treatment of adult and pediatric patients aged **1 year and older**, weighing at least **15 kg**, with eosinophilic esophagitis (EoE)
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Update policy with new indication.

Prior Authorization Criteria for **Commercial/Medicaid**:

PA PROGRAM NAME	Dupixent
MEDICATION NAME	Dupixent
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
REQUIRED MEDICAL INFORMATION	For Eosinophilic Esophagitis (EoE), all the following must be met for initial authorization: 1. Diagnosis of eosinophilic esophagitis, defined as all of the following: a) Eosinophil-predominant inflammation on esophageal biopsy with greater than or equal to 15 eosinophils per high power field (HPF) b) Symptoms of esophageal dysfunction such as dysphagia, chest pain, stomach pain, heartburn, regurgitation, and vomiting 2. Patient weighs at least 15 kg 3. Patient had an inadequate response to one of the following therapies, or has an intolerance/contraindication to all of the following therapies: a) Eight weeks of a proton pump inhibitor b) Eight weeks of a topical glucocorticoid (e.g., fluticasone inhaler, swallowed budesonide)

7. **Vabysmo** (faricimab-svoa)
    a. Previous Indication(s):
        a. Neovascular (Wet) Age-Related Macular Degeneration (nAMD)
        b. Diabetic Macular Edema (DME)
    b. New indication approved 10/26/2023:
        a. Macular Edema Following Retinal Vein Occlusion (RVO)
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Update policy with new indication.

Prior Authorization Criteria for **Commercial/Medicaid/Medicare Part B**:

PA PROGRAM NAME	Ophthalmic Vascular Endothelial Growth Factor (VEGF) Inhibitors
MEDICATION NAME	Vabysmo
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
REQUIRED MEDICAL INFORMATION	**Macular edema following retinal vein occlusion:** a. For ranibizumab (Lucentis®) and faricimab (Vabysmo®): Documentation that ALL of the following agents have been ineffective, not tolerated, or contraindicated or rationale is provided why therapy is not appropriate for the patient: i. bevacizumab ii. aflibercept (Eylea®) iii. ranibizumab-nuna (Byooviz®) or ranibizumab-eqrn (Cimerli®)

Therapies with Prior Authorization Policies (Oncology)

1. **Welireg** (belzutifan)
    a. New indication(s) approved 12/14/2023:
        i. Von Hippel-Lindau (VHL) disease:
            - Treatment of adult patients with von Hippel-Lindau (VHL) disease who require therapy for associated renal cell carcinoma (RCC), central nervous system (CNS) hemangioblastomas, or pancreatic neuroendocrine tumors (pNET), not requiring immediate surgery
        ii. Advanced Renal Cell Carcinoma:
            - Treatment of adult patients with advanced renal cell carcinoma (RCC) following a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI)
    b. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Prior authorization policy coverage criteria are based on recommendations from the National Comprehensive Cancer Network (NCCN); no updates to the policy are warranted.

2. **Keytruda** (dabrafenib)
    a. New indication(s) approved 12/15/2023, 1/12/2024, 1/25/2023:
        i. Urothelial Cancer:
            - In combination with enfortumab vedotin, for the treatment of adult patients with locally advanced or metastatic urothelial cancer
        ii. Cervical Cancer:
            - In combination with chemoradiotherapy, for the treatment of patients with FIGO 2014 Stage III-IVA cervical cancer
        iii. Adult Classical Hodgkin Lymphoma and Adult Primary Mediastinal Large B-Cell Lymphoma: Additional Dosing Regimen of 400 mg Every 6 Weeks:
            - MSI-H or dMMR Endometrial Carcinoma: 200 mg every 3 weeks or 400 mg every 6 weeks
        iv. Hepatocellular Carcinoma:
            - For the treatment of patients with HCC secondary to hepatitis B who have received prior systemic therapy other than a PD1/PD-L1-containing regimen
    b. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Prior authorization policy coverage criteria are based on recommendations from the National Comprehensive Cancer Network (NCCN); no updates to the policy are warranted.

3. **Padcev** (enfortumab)
    a. New indication(s) approved 12/15/2023:
        i. In combination with pembrolizumab for the treatment of adult patients with locally advanced or metastatic urothelial cancer
    b. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Prior authorization policy coverage criteria are based on recommendations from the National Comprehensive Cancer Network (NCCN); no updates to the policy are warranted.

4. **Piquay** (alpelisib)
    a. New indication(s) approved 1/18/2024:

i. In combination with fulvestrant for the treatment of adults with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer as detected by an FDA-approved test following progression on or after an endocrine-based regimen

b. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Prior authorization policy coverage criteria are based on recommendations from the National Comprehensive Cancer Network (NCCN); no updates to the policy are warranted.

5. **Balversa** (erdafitinib)
   a. New indication(s) approved 1/19/2024:
      i. Treatment of adult patients with locally advanced or metastatic urothelial carcinoma (mUC) with susceptible FGFR3 genetic alterations whose disease has progressed on or after at least one line of prior systemic therapy
   b. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Prior authorization policy coverage criteria are based on recommendations from the National Comprehensive Cancer Network (NCCN); no updates to the policy are warranted.

<u>Therapies Without Prior Authorization Policies</u>

1. **Zynrelef** (bupivacaine/meloxicam)
   a. Previous Indication(s):
      i. Indicated in adults for soft tissue or periarticular instillation to produce postsurgical analgesia for up to 72 hours after foot and ankle, small-to-medium open abdominal, and lower extremity total joint arthroplasty surgical procedures
   b. New indication approved 1/23/2024:
      i. Indicated in adults for postsurgical analgesia for up to 72 hours after:
         1. Soft tissue surgical procedures
         2. Orthopedic surgical procedures
            a. Foot and ankle procedures
            b. Other orthopedical surgical procedures (e.g., total joint arthroplasty) in which direct exposure to articular cartilage is avoided
   c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert.

2. **Avycaz** (avibactam sodium; ceftazidime)
   a. Previous Indication(s):
      i. Indicated for the treatment of the following infections caused by designated susceptible Gram-negative microorganisms in adult and pediatric patients aged 3 months and older:
         1. Complicated Intra-abdominal Infections (cIAI), used in combination with metronidazole
         2. Complicated Urinary Tract Infections (cUTI), including Pyelonephritis
         3. Hospital-acquired Bacterial Pneumonia and Ventilator-associated Bacterial Pneumonia (HABP/VABP)
   b. New indication approved 1/26/2024:
      i. Indicated for the treatment of the following infections caused by designated susceptible Gram-negative microorganisms in adult and pediatric patients (at least **31 weeks gestational age**):
         1. Complicated Intra-abdominal Infections (cIAI), used in combination with metronidazole

2. Complicated Urinary Tract Infections (cUTI), including Pyelonephritis
3. Hospital-acquired Bacterial Pneumonia and Ventilator-associated Bacterial Pneumonia (HABP/VABP)

c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert.

Drug Safety Monitoring:

FDA Drug Safety Communications

1. **Drug Name: All FDA-Approved GLP-1 RAs**
   - **Date Posted: 1/11/2024**
   - **Safety Alert Title: Update on FDA's ongoing evaluation of reports of suicidal thoughts or actions in patients taking a certain type of medicines approved for type 2 diabetes and obesity**
   - **Link to more information:** https://www.fda.gov/drugs/drug-safety-and-availability/update-fdas-ongoing-evaluation-reports-suicidal-thoughts-or-actions-patients-taking-certain-type
   - **What safety concern is FDA announcing?**
     - The U.S. Food and Drug Administration (FDA) has been evaluating reports of suicidal thoughts or actions in patients treated with a class of medicines called glucagon-like peptide-1 receptor agonists (GLP-1 RAs; see the list in Table 1 below). These medicines are used to treat people with type 2 diabetes or to help those with obesity or overweight to lose weight. FDA's preliminary evaluation has not found evidence that use of these medicines causes suicidal thoughts or actions.
   - **What is FDA doing?**
     - FDA has conducted detailed reviews of reports of suicidal thoughts or actions received in the FDA Adverse Event Reporting System (FAERS). Because the information provided was often limited and because these events can be influenced by other potential factors, FDA determined that the information in these reports did not demonstrate a clear relationship with the use of GLP-1 RAs. Similarly, FDA's review of the clinical trials, including large outcome studies and observational studies, did not find an association between use of GLP-1 RAs and the occurrence of suicidal thoughts or actions. However, because of the small number of suicidal thoughts or actions observed in both people using GLP-1 RAs and in the comparative control groups, FDA cannot definitively rule out that a small risk may exist; therefore, the FDA is continuing to look into this issue. Additional evaluations include a meta-analysis of clinical trials across all GLP-1 RA products and an analysis of post marketing data in the Sentinel System External Link Disclaimer. A meta-analysis is a large, combined analysis of findings from clinical trials. Sentinel is a very large data network that contains health insurance claims and patient health records that can be used to investigate safety questions about FDA-regulated products. FDA will communicate the final conclusions and recommendations after a complete review or have more information to share.
   - **What should health care professionals do?**
     - Health care professionals should monitor for and advise patients using GLP-1 RAs to report new or worsening depression, suicidal thoughts, or any unusual changes in mood or behavior.
     - Health care professionals should consult the prescribing information when treating patients with these medications.
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

2. **Drug Name: Denosumab (Prolia)**
   - **Date Posted: 1/19/2024**

- **Safety Alert Title: FDA adds Boxed Warning for increased risk of severe hypocalcemia in patients with advanced chronic kidney disease taking osteoporosis medicine Prolia (denosumab)**
- **Link to more information:** https://www.fda.gov/drugs/drug-safety-and-availability/fda-adds-boxed-warning-increased-risk-severe-hypocalcemia-patients-advanced-chronic-kidney-disease
- **What safety concern is FDA announcing?**
  - Based on a completed U.S. Food and Drug Administration (FDA) review of available information, FDA has concluded that the osteoporosis medicine Prolia (denosumab) increases the risk of severe hypocalcemia, very low blood calcium levels, in patients with advanced chronic kidney disease (CKD), particularly patients on dialysis. Severe hypocalcemia appears to be more common in patients with CKD who also have a condition known as mineral and bone disorder (CKD-MBD). In patients with advanced CKD taking Prolia, severe hypocalcemia resulted in serious harm, including hospitalization, life-threatening events, and death. As a result, the FDA is revising the Prolia prescribing information to include a new Boxed Warning, FDA's most prominent warning, communicating this increased risk. Severe hypocalcemia can be asymptomatic or may present with symptoms that include confusion; seizures; irregular heart rhythm; fainting; face twitching; uncontrolled muscle spasms; or weakness, tingling, or numbness in parts of the body.
- **What is FDA doing?**
  - FDA is adding a Boxed Warning to the Prolia prescribing information about the significant risk of developing severe hypocalcemia in patients with advanced CKD. This warning abend new labeling contains information to help reduce this risk, including appropriate patient selection for Prolia treatment, increased monitoring of blood calcium levels, and other strategies. This updated information is also being added to the patient Medication Guide and the Prolia Risk Evaluation and Mitigation Strategy (REMS), a drug safety program required by FDA to help ensure that Prolia's benefits outweigh its risks.
- **What should health care professionals do?**
  - It is important that the appropriateness of Prolia treatment in patients with advanced CKD be determined by a health care professional with expertise in the diagnosis and management of CKD-MBD including renal osteodystrophy, a complication that weakens bone. Treating bone disease in patients with advanced and dialysis-dependent CKD is challenging because of the difficulty in diagnosing and confirming the underlying altered bone metabolism responsible for the low bone mass and increased fracture risk, and the complex benefit-risk considerations of approved osteoporosis treatments in this population.
  - Before prescribing Prolia, health care professionals should assess their patients' kidney function. For patients with advanced CKD, particularly those on dialysis, health care professionals should consider the risk of severe hypocalcemia with Prolia in the context of other available treatments for osteoporosis. If Prolia is still being considered for these patients, for initial or continued use, check their calcium blood levels and assess them for evidence of CKD-MBD. Treatment with Prolia in patients with advanced CKD, including those on dialysis, and particularly patients with diagnosed CKD-MBD should involve a health care provider with expertise in the diagnosis and management of CKD-MBD. Proper management of CKD-MBD, correction of hypocalcemia, and supplementation with calcium and activated vitamin D prior to Prolia treatment is expected to decrease the risk of developing severe hypocalcemia and any associated complications. Following Prolia administration, close monitoring of blood calcium levels and prompt management of hypocalcemia is essential to prevent complications such as seizures or arrhythmias. Advise patients to promptly report symptoms that could be consistent with hypocalcemia.
- **Health Plan Recommendation:** Notify providers via Medical Policy Alert

Drug Recalls/Market Withdrawals

1. **Drug Name:** Vigabatrin for Oral Solution, USP 500 mg
   - **Date of Recall:** 12/18/2023
   - **Reason for recall:** Due to seal integrity issues allowing for powder leakage from the pouch.
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/invagen-pharmaceuticals-issues-voluntary-nationwide-recall-vigabatrin-oral-solution-usp-500mg-due
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

2. **Drug Name:** Bleomycin for Injection, USP 15 Units Single Dose ONCO-TAIN™ Glass Fliptop Vial
   - **Date of Recall:** 12/22/2023
   - **Reason for recall:** Presence of Glass Particulate Matter
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/hospira-inc-issues-voluntary-nationwide-recall-one-lot-bleomycin-injection-usp-15-units-single-dose
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

3. **Drug Name:** Americaine® 20% Benzocaine Topical Anesthetic Spray
   - **Date of Recall:** 12/22/2023
   - **Reason for recall:** Presence of benzene
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/insight-pharmaceuticals-issues-voluntary-nationwide-recall-americainer-20-benzocaine-topical
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

4. **Drug Name:** 4.2% Sodium bicarbonate injection, 8.4% Sodium bicarbonate injection, Atropine sulfate injection
   - **Date of Recall:** 12/26/2023
   - **Reason for recall:** Presence of Glass Particulate Matter
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/hospira-inc-issues-voluntary-nationwide-recall-42-sodium-bicarbonate-injection-84-sodium-bicarbonate
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

5. **Drug Name:** Vancomycin IV Bags, Phenylephrine IV Bags, and Fentanyl IV Bags
   - **Date of Recall:** 1/08/2024
   - **Reason for recall:** Potential for super potent drug
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/leiters-health-issues-voluntary-nationwide-recall-vancomycin-iv-bags-phenylephrine-iv-bags-and
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

6. **Drug Name:** Lubricant Gel Drops 15mL, Lubricant Eye Drops 15mL (Twin Pack)
   - **Date of Recall:** 1/22/2024
   - **Reason for recall:** Device & Drug Safety Potential Safety Concerns
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/kilitch-healthcare-india-limited-issues-amendments-last-voluntary-nationwide-recall-press-release
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

7. **Drug Name:** Robitussin Honey CF Max Day Adult 4oz, Robitussin Honey CF Max Day Adult 8oz, Robitussin Honey CF Max NT Adult 8oz
   - **Date of Recall:** 1/24/2024
   - **Reason for recall:** Microbial Contamination
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/haleon-issues-voluntary-nationwide-recall-robitussin-honey-cf-max-day-adult-and-robitussin-honey-cf
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

8. **Drug Name:** Zenzedi® (dextroamphetamine sulfate tablets, USP) 30 mg
   - **Date of Recall:** 1/25/2024
   - **Reason for recall:** Mislabeled package
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/azurity-pharmaceuticals-inc-issues-voluntary-nationwide-recall-zenzedir-dextroamphetamine-sulfate
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

9. **Drug Name:** Neptune's Fix Elixir, Neptune's Fix Extra Strength Elixir, and Neptune's Fix Tablets
   - **Date of Recall:** 11/15/2023
   - **Reason for recall:** Undeclared Tianeptine
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/neptune-resources-llc-issues-voluntary-nationwide-recall-neptunes-fix
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

Other Formulary Changes:

OTHER FORMULARY CHANGES		
Drug Name	**Action Taken**	**Policy Name**
Ropeginterferon alfa-2b-njft (Besremi) Syringe	Add to Commercial Formulary, Tier 6, Prior Authorization	Anti-Cancer Medications - Self-Administered
Leuprolide acetate (Eligard) Disp Syringe	Remove from Commercial, Medicaid, and Medicare Part D formularies, as requires healthcare	Gonadotropin Releasing Hormone Agonists

	professional administration (changed to medical benefit coverage) Effective date: 07/01/2024	
Metoprolol Tartrate 37.5 mg and 75 mg Tablet	• Commercial Standard: Change from Tier 2 to Tier 1 • Medicare Part D: Add to Formulary, Tier 1 Effective date: 05/01/2024	N/A
Adapalene/benzoyl peroxide/clindamycin phosphate (Cabtreo) Gel	New strength; • Commercial/Medicaid: Non-Formulary, Prior Authorization • Medicare Part D: Non-Formulary	• Commercial/Medicaid: New Medications and Formulations without Established Benefit • Medicare Part D: N/A
Oxaprozin (Coxanto) Capsule	New strength; • Commercial/Medicaid: Non-Formulary, Prior Authorization • Medicare Part D: Non-Formulary	• Commercial/Medicaid: New Medications and Formulations without Established Benefit • Medicare Part D: N/A
Dapagliflozin Propanediol (Farxiga) Tablet	Add generic to Medicaid formulary; Remove brand	N/A
Sotagliflozin (Inpefa)	Remove from Medicaid formulary	N/A
• **Canagliflozin (Invokana) Tablet** • **Canagliflozin/metformin hcl (Invokamet) Tablet** • **Canagliflozin/metformin hcl (Invokamet XR) Tablet PB 24h**	• Commercial: Remove from formulary • Medicaid: Add to formulary (preferred on Preferred Drug List from Oregon Health Authority)	N/A
Cyclosporine (Veyve) 0.1% drops	New Strength Non-formulary for all lines of business	N/A

The formulary status for the following drugs was line extended in accordance with Providence Health Plan Pharmacy Operational Policy ORPTCOPS062

INFORMATIONAL ONLY

NEW DRUGS / COMBINATIONS / STRENGTHS / DOSAGE FORMS		
Drug Name	**Action Taken**	**Policy Name**
Bosutinib (Bosulif) Capsule	New dosage form (capsule) and strength. Line extend with Bosulif tablets; • Commercial: Formulary, Tier 6, Prior Authorization	Anti-Cancer Medications - Self-Administered

	• Medicaid: Formulary, Prior Authorization • Medicare Part D: Formulary, Tier 5, Prior Authorization	
Emicizumab-kxwh (Hemlibra) Vial	New strength (300mg/2ml). Line extend with existing Hemlibra; • Commercial/Medicaid: Medical Benefit, Prior Authorization, Specialty • Medicare Part D: Non-Formulary • Medicare Part B: Medical Benefit, Prior Authorization	Hemlibra
Omalizumab (Xolair) Auto Injct / Syringe	New formulation. Line extend with existing Xolair; • Commercial: Formulary, Tier 5, Prior Authorization • Medicaid: Formulary, Prior Authorization • Medicare Part D: Formulary, Tier 5, Prior Authorization	Xolair / Self-Administered Drugs (SADs)

NEW GENERICS		
Drug Name	**Action Taken**	**Policy Name**
Bromfenac sodium Drops	First generic (Prolensa). Line extend as generic; • Commercial Standard: Formulary, Tier 2 • Commercial Dynamic: Formulary, Tier 4 • Medicaid: Non-Formulary • Medicare Part D: Formulary, Tier 3	N/A
Valsartan Solution	First generic. Line extend as generic; • Non-Formulary for all line of business	N/A
Cefazolin sodium Vial	First generic drug. Line extend as generic; • Medical benefit for all lines of business	N/A
Dabigatran etexilate 110 mg Capsule	First generic drug. Line extend as generic; • Commercial Standard: Formulary, Tier 2 • Commercial Dynamic: Formulary, Tier 3 • Medicaid: Formulary • Medicare Part D: Formulary, Tier 4	N/A
Loteprednol etabonate Drops Susp	First generic drug (Alrex). Line extend as generic; • Commercial Standard: Formulary, Tier 2 • Commercial Dynamic: Formulary, Tier 4	N/A

	• Medicaid: Non-Formulary • Medicare Part D: Formulary, Tier 3	
Deflazacort Tablet	First generic drug (Emflaza). Line extend as generic; • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 tablets per day) • Medicare Part D: Non-Formulary, Prior Authorization, Quantity Limit (2 tablets per day)	Emflaza
Mifepristone Tablet	First generic drug (Korlym). Line extend as generic; • Commercial/Medicaid: Non-Formulary, Prior Authorization • Medicare Part D: Formulary, Tier 5	Korlym
Gabapentin (Gabapentin ER) Tab ER 24h	First generic drug (Gralise). Line extend with generic; • Commercial/Medicaid: Non-Formulary, Prior Authorization • Medicaid Part D: Non-Formulary	• Commercial/Medicaid: New Medications and Formulations without Established Benefit • Medicare Part D: N/A

Clinical Policy Changes:

MAJOR CHANGES	
Policy Name	**Summary of Change**
Disposable Insulin Pumps	Increased quantity limit on insulin pods
Egrifta	Policy criteria has been updated to allow auto-processing at point of sale (PO) if diagnoses listed on the policy are submitted on the claim.
• **Enzyme Replacement Therapy** • **Enzyme Replacement Therapy Prior Authorization and Step Therapy Policy – Medicare Part B**	New drug Adzynma for congenital thrombotic thrombocytopenic purpura added to policy. Updated prescriber restrictions to include hematologist and oncologist.
GLP-1/GIP Receptor Agonists	Adlyxin® was removed from the policy as this medication is no longer available on the market.
• **Hepatitis C - Direct Acting Antivirals** • **Hepatitis C - Direct Acting Antivirals - Medicaid**	Updated to allow coverage for patients receiving a donor solid organ from a donor infected with the hepatitis C virus.
Hormone Replacement Therapy Prior Authorization and Step Therapy Policy – Medicare Part B	Clarified that elevated luteinizing hormone (LH)/follicle-stimulating hormone (FSH) is indicative of primary hypogonadism, but low LH/FSH requires further assessment of chronic conditions.
• **Human Growth Hormones** • **Human Growth Hormones - Medicaid**	Updated quantity limit language to be based on FDA labeling for all uses. Removed obsolete drugs Saizen® and Zorbtive® and all references to Short Bowel Syndrome.

• **Medical Nutrition – Commercial** • **Medical Nutrition – Medicaid**	Clarified medical food coverage and definition of inborn errors of metabolism.
Non-Preferred Insulins	Policy was updated to only include Apidra®, as this is the only non-preferred insulin on the formulary. All other non-preferred insulins are non-formulary and will be reviewed according to the formulary exception policy.
Osteoanabolic Agents	Simplified medical necessity criteria. Removed prescriber restrictions and the exclusion for history of myocardial infarction/stroke.
Osteoanabolic Agents Prior Authorization and Step Therapy Policy - Medicare Part B	Simplified medical necessity criteria. Removed prescriber restrictions and the exclusion for history of myocardial infarction/stroke.
• **Oxlumo** • **Oxlumo Prior Authorization and Step Therapy Policy – Medicare Part B**	Removed exclusion of estimated glomerular filtration rate less than 30 due to FDA labeling updates.
Palynziq	Increased reauthorization coverage duration to until no longer eligible with the plan.
Pituitary Disorder Therapies	Endocrine specialist consulted regarding Cushing's Syndrome criteria: 1. Removed criteria requiring baseline liver tests as no further evaluation of enzyme labs are required in prior authorization review. The safety warnings regarding monitoring of hepatic function are outlined in the package insert, will leave to providers to assess. 2. Removed criteria regarding documentation of baseline urinary free cortisol as policy already requires documentation of a diagnosis of Cushing's syndrome.
Revcovi	Increased initial and reauthorization coverage duration to one year.
Tarpeyo	FDA label changed and this therapy is now approved for all adults with primary immunoglobulin A nephropathy (IgAN) who are at risk for disease progression [not just those at risk of rapid progression (urine protein creatinine ratio > 1.5 g/g)]. Updated criteria to allow for urine protein creatinine ratio ≥0.8 g/g or proteinuria ≥1 g/day to align with study inclusion criteria. Clarified timeframe of three months that individual must be on ACE-i/ARB therapy.
• **Tepezza** • **Tepezza Prior Authorization and Step Therapy Policy - Medicare Part B**	Removed exclusion for sight-threatening disease and updated thyroid requirement to include free thyroid levels.
Tolvaptan	Simplified criteria for autosomal dominant polycystic kidney disease (ADPKD) to allow for provider attestation of diagnosis and whether the patient is experiencing rapidly progressive disease.
Vijoice	Simplified reauthorization criteria and increased coverage duration from six months to one year, clarified where supporting documentation is required, clarified that prescriber restrictions apply to initial and reauthorization.

RETIRED	
Imcivree	Added to Medications for Rare Indications' policy
Kuvan	Due to generic availability and low risk of overutilization

• **SGLT-2 Inhibitors - Commercial** • **SGLT-2 Inhibitors - Medicaid**	1. Preferred products are covered without prior authorization. 2. Non-preferred products will be non-formulary and formulary exception criteria will apply.

Appendix A: Claims Associated with Non-Covered Services

CPT Code List (may not be all inclusive, and subject to change)

0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis

0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia
0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device
0621T	Trabeculostomy ab interno by laser
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance
0643T	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach
0644T	Transcatheter removal or debulking of intracardiac mass (eg, vegetations, thrombus) via suction (eg, vacuum, aspiration) device, percutaneous approach, with intraoperative reinfusion of aspirated blood, including imaging guidance, when performed
0645T	Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed
0646T	Transcatheter tricuspid valve implantation/replacement (TTVI) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed
0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging
0656T	Anterior lumbar or thoracolumbar vertebral body tethering, anterior; up to 7 vertebral segments
0657T	Anterior lumbar or thoracolumbar vertebral body tethering, anterior; 8 or more vertebral segments
0673T	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance
0674T	Laparoscopic insertion of new or replacement of permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including an implantable pulse generator and diaphragmatic lead(s)
0675T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first lead
0676T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional lead (List separately in addition to code for primary procedure)
0677T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first repositioned lead
0678T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional repositioned lead (List separately in addition to code for primary procedure)
0679T	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function

0680T	Insertion or replacement of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing lead(s)
0681T	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing dual leads
0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)
0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed

0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve
C9764	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed
C9765	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed
C9766	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed
C9767	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed
C9781	Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)
0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens ***(Effective 7/1/2020)***
0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens *(Effective 7/1/2020)*
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange *(Effective 7/1/2020)*
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
27599	Unlisted procedure, femur or knee
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
69714	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor
69716	Osseointegrated implant insertion with magnetic transcutaneous attachment to a speech processor

69717	Revision (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor
69719	Revision or replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex
69726	Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor
69727	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex
69728	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex
69729	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex
69730	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19361	Breast reconstruction with latissimus dorsi flap
19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
19370	Revision of peri-implant capsule, breast, including capsulotomy, and /or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes
10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)

15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (e.g. keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy, cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (list separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
17340	Cryotherapy (CO_2 slush, liquid N_2) for acne
17360	Chemical exfoliation for acne (eg, acne paste, acid)
19300	Mastectomy for gynecomastia
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)

21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21137	Reduction forehead; contouring only
21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
21270	Malar augmentation, prosthetic material
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
54360	Plastic operation on penis to correct angulation
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis, same operative session
56800	Plastic repair of introitus
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57291	Construction of artificial vagina, without graft
57292	Construction of artificial vagina, with graft
69320	Reconstruction external auditory canal for congenital atresia, single stage
69300	Otoplasty, protruding ear, with or without size reduction
69930	Cochlear device implantation, with or without mastoidectomy
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)
61880	Revision or removal of intracranial neurostimulator electrodes
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays

61888	Revision or removal of cranial neurostimulator pulse generator or receiver
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67921	Repair of entropion; suture
67922	Repair of entropion; thermocauterization
67923	Repair of entropion; excision tarsal wedge
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
0588T	Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed
64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)
64585	Revision or removal of peripheral neurostimulator electrode array
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open

43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed
43285	Removal of esophageal sphincter augmentation device
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
21070	Coronoidectomy (separate procedure)
21125	Augmentation, mandibular body or angle; prosthetic material

21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete
29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)
28446	Open osteochondral autograft, talus (includes obtaining graft[s])

0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
0275T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace
22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)
22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar

22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments
22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; thoracic
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical

63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)

63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment
63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace
63078	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)
63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
63086	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (List separately in addition to code for primary procedure)
63087	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment
63088	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)
63090	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment
63091	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)
63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment
63102	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment
63103	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)
63170	Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumbar
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical

63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53446	Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53447	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session
53449	Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia), limb or trunk
36470	Injection of sclerosing solution; single vein
36471	Injection of sclerosing solution; multiple veins, same leg
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated

36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37718	Ligation, division, and stripping, short saphenous vein
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report
21685	Hyoid myotomy and suspension
30140	Submucous resection inferior turbinate, partial or complete, any method
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array
64583	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator
64584	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array

Appendix B: Low Acuity Non-Emergent Diagnosis Codes

A64	F5102	H00013	H10232	H11019	H60511
B002	F5103	H00014	H10233	H11041	H60512
B009	F5109	H00015	H10239	H11042	H60513
B019	F5119	H00016	H1030	H11043	H60519
B029	F513	H00019	H1031	H11049	H60521
B070	F514	H0011	H1032	H11152	H60522
B079	F515	H0012	H1033	H11153	H60523
B081	F518	H0013	H10401	H11222	H60529
B084	F519	H0014	H10402	H11412	H60531
B085	F952	H0015	H10403	H11421	H60532
B09	F958	H0016	H10409	H11422	H60533
B2780	F959	H0019	H10411	H11423	H60539
B2790	F985	H01001	H10412	H11429	H60541
B2799	G43109	H01002	H10413	H1189	H60542
B338	G43809	H01003	H10419	H119	H60543
B350	G43909	H01004	H1045	H5710	H60549
B354	G43B0	H01005	H10501	H578	H60551
B355	G43C0	H01006	H10502	H60311	H60552
B370	G43D0	H01009	H10503	H60312	H60553
B373	G441	H019	H10509	H60313	H60559
B3783	G44209	H10011	H10511	H60319	H60591
B379	G5600	H10012	H10512	H60331	H60592
B86	G5601	H10013	H10513	H60332	H60593
B9710	G5602	H10019	H10519	H60333	H60599
B9711	G5621	H10021	H1089	H60339	H6060
B974	G5622	H10022	H109	H60391	H6061
B9789	G5631	H10023	H11001	H60392	H6062
E109	G5691	H10029	H11002	H60393	H6063
E118	G5692	H1010	H11003	H60399	H608X1
E119	G609	H1011	H11009	H60501	H608X2
F508	G8929	H1012	H11011	H60502	H608X3
F509	H00011	H1013	H11012	H60503	H608X9
F5101	H00012	H10231	H11013	H60509	H6090

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K8020	L2481	L603	L731	M25512	M6248
L0292	L2489	L604	L732	M25519	M62830
L0293	L249	L605	L738	M25521	M62831
L0591	L250	L608	L739	M25522	M62838
L0592	L251	L609	L740	M25529	M65812
L089	L252	L62	L741	M25531	M65832
L2081	L253	L630	L742	M25532	M65841
L2082	L254	L631	L743	M25539	M65842
L2084	L255	L632	L744	M25561	M65862
L2089	L258	L638	L74510	M25562	M6588
L209	L259	L639	L74511	M25569	M67351
L210	L270	L640	L74512	M25571	M67352
L218	L271	L648	L74513	M25572	M67361
L219	L272	L649	L74519	M25579	M67362
L22	L279	L651	L7452	M2660	M7021
L230	L299	L652	L748	M2669	M7022
L231	L300	L658	L749	M2679	M7041
L232	L301	L659	L750	M5117	M7051
L233	L302	L660	L751	M533	M7052
L234	L308	L662	L752	M5410	M7061
L235	L309	L663	L758	M5416	M7062
L236	L42	L668	L759	M5417	M7071
L237	L500	L669	L84	M542	M722
L2381	L509	L700	L853	M5430	M75102
L2389	L550	L701	L983	M5431	M7521
L239	L551	L703	M109	M5432	M7522
L240	L559	L705	M2390	M5440	M7531
L241	L562	L708	M2391	M5441	M7541
L242	L563	L709	M2392	M5442	M7542
L243	L569	L720	M25461	M546	M7551
L244	L578	L723	M25462	M5489	M7552
L245	L600	L728	M25469	M549	M7581
L246	L601	L729	M2550	M6088	M7582
L247	L602	L730	M25511	M609	M7591

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