Providence Health Plan

Providence Health Assurance

Healthcare Services Medical & Pharmacy Policy Alerts

Number 96

July 1, 2024

This is the July 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

Updated Effective Date: *8/1/2024*

High Dollar Drug Reviews

Providence Health Plan/Providence Health Assurance may review drugs used in inpatient stays when the billed amount meets or exceeds $10,000. In addition to medical appropriateness, we will review for the reasonableness of the charges submitted against average sales pricing (ASP) or average wholesale price (AWP) for each drug. If the billed charges for the drug(s) selected for review are marked up by 150% or more of ASP or 100% of the AWP, the drug will be **denied as not reimbursable**. Facilities will need to provide justification for the excessive billed charge or rebill with standard pricing. *Provider contract language may apply and will supersede this policy, including but not limited to, negotiated fee schedule amounts.*

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.

Emergency Room Evaluation & Management Services

Providence Health Plan/Providence Health Assurance will begin to address appropriate levels of evaluation & management (E&M) services based on the complexity of the condition rendered in the emergency department. When a physician or facility bills an E&M level 4 (99284) or level 5 (99285) with a low acuity non-emergent (LANE) diagnosis code, The Plan will **deny the E&M services as not reimbursable**. In order to be considered for reimbursement, a corrected claim using the appropriate lower-level E&M code (e.g., 99281-99283) corresponding to the lower complexity diagnosis code(s) must be submitted. A complete list of LANE diagnosis codes is included in Appendix B below.

Providence Health Plan

Providence Health Assurance

MEDICAL

COMPANY POLICIES

Effective 7/1/2024

Wheelchairs and Power Vehicles **MP140**	**Policy Updates:** • Added to Criterion LVIII to provide background on why Group 2 POVs are not considered medically necessary. • Reformatted Criterion LXXXII.A, but no change to the intent of coverage. Ever since seat elevation systems have been eligible for coverage (May 2023), coverage has only been possible when used with certain types of power wheelchairs. Policy revisions with this version are based on updated LCD language. *Of note, the LCD language does not include Group 5 (pediatric) power-driven wheelchairs, however, since pediatrics is associated with non-Medicare LOB, we are keeping this coverage in our non-Medicare policy*. • No change to other criteria in the policy. • Updated "Billing Guidelines" to reflect the code change from E2300 to E2298 that took place 4/1/2024. • Updated "Billing Guidelines" to add correct and incorrect uses for HCPCS K0108. **Codes/PA:** No change to codes or configuration. **OHP:** OHP will follow the Company Policy above

Effective 8/1/2024

Genetic Testing for Hereditary Breast, Ovarian and Pancreatic Cancer Testing **MP143** *Previously: Genetic Testing: Hereditary Breast and Ovarian Cancer Testing*	**Policy Updates:** • Expanded policy scope to address hereditary pancreatic cancer testing. • Added hereditary pancreatic cancer testing to policy. Indications share same targeted genes with one additional gene for pancreatic cancer. • NCCN groups these hereditary cancers together. **Codes/PA:** No change to codes or configuration. **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.
Glycated Hemoglobin and Glycated Protein Diagnostic Testing **MP267**	**Policy Updates:** No changes to criteria. Lab management policy based on CMS guidance **Codes/PA:** Several new dx codes added to pair-to-pay configuration. **OHP:** OHP will follow the Company Policy above
Protein Biomarker and Genetic Testing for the Prostate **MP86**	**Policy Updates:** Included biomarker testing to include tests listed in the NCCN guideline for Prostate Early Detection. This would include tests that should be considered pre-biopsy to help determine if biopsy was needed. **Codes/PA:** Changed from NMN to PA for following codes: 0005U, 81539 **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.

Effective 9/1/2024

Prolotherapy **MP200**	**Policy Updates:** Changed denial language from investigational to not medically necessary. **Codes/PA:** Changed M0076 to deny as not medically necessary. **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.

Blood Counts **MP208**	**Policy Updates:** Updated pair to deny diagnosis codes per updated NCD. **Codes/PA:** Updated pair to deny diagnosis codes from CMS, please see CRW. (Codes added and removed) **OHP:** These changes do not apply to OHP. The Prioritized List and the Oregon Administrative Rules will be followed.
Breast Reconstructive Surgery, Reduction Mammoplasty, and Implant Management **MP58**	**Policy Updates:** Updated criterion III to reflect that skin substitutes need to be approved for breast reconstruction in the Skin and Tissue Substitute medical policy. **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 7/1/2024

Pneumatic Compression Devices ***Formerly:*** *Compression: Outpatient Pneumatic Devices* **MP138**	**Policy Updates:** • No change to criteria. Continue to apply Medicare references, except when used for lymphedema caused by mastectomy, which the plan will consider to be medically necessary without application of any other medical necessity criteria (except possible frequency limits). • Add clarification that while we allow this coverage, utilization is still expected to be reasonable and necessary, including the frequency of the replacement of equipment. • Update title to remove ":" symbol. **Codes/PA:** No change to codes or configuration.

Cardiac Disease Risk Screening ***Formerly:*** *Cardiac: Disease Risk Screening* **MP132**	**Policy Updates:** • Update title to remove ":" symbol. • Continue to apply Medicare criteria for services already using Medicare coverage criteria. • For services currently using Company policy criteria, added general Medicare regulatory coverage rules to use for testing used for asymptomatic individuals. • Added an LCD for additional geographical service areas. • Added CARDIO inCode-Score by name to the criteria table, but the code for this test has been in the policy for the past year, so no change to non-coverage position. • Added a "Background" section to the Policy Guidelines. • Added a code table to Billing Guidelines section. **Codes/PA:** • Q3 2024 Code updates: ○ **Add:** 0466U (NMN) • No change to other codes or configuration of codes already on the policy.

Skin and Tissue Substitutes
 	
MP371
	Policy Updates: Added Noridian LCD for amniotic and placental-derived product injections and/or applications for musculoskeletal (**non-wound**) indications. This LCD is not new, however, since this policy is generally used for wound indications, it wasn't included in this policy, but has been used in a separate Medicare medical policy.
	Codes/PA:
	• No changes to codes or configuration to codes in the policy, aside from what is part of the Q3 2024 code updates.
	• Q3 2024 Code updates:
	  ○ **Add:** Q4311, Q4312, Q4313, Q4314, Q4315, Q4316, Q4317, Q4318, Q4319, Q4320, Q4321, Q4322, Q4323, Q4324, Q4325, Q4326, Q4327, Q4328, Q4329, Q4330, Q4331, Q4332, Q4333 (NMN)
	  ○ **Delete/Term/Discontinue:** Q4210, Q4277

Effective 8/1/2024

Allergy Testing **MP152**	**Policy Updates:** No change to criteria, but some minor changes made: • Updated "Policy Guidelines" to emphasize all units must be "medically reasonable and necessary" for the individual member. • Updated "Billing Guidelines" to match configuration set up in system and/or align with Medicare. Several of the quantity limit notes in the policy are not actually used for Medicare LOB. Other codes have configuration in place that are more restrictive than Medicare guidance. Therefore, updated the billing guideline language, emphasizing that all units must be "medically reasonable and necessary" for the individual member. **Codes/PA:** Updated configuration on codes that were more restrictive than CMS MUEs.
Magnetic Esophageal Ring for Gastroesophageal Reflux Disease (GERD) ***Formerly:*** *Gastroesophageal Reflux: Magnetic Esophageal Ring* **MP394**	**Policy Updates:** No change to criteria for implantation, or for removal **with** replacement with a new device. Updated criteria for removal **without** replacement of a new device. **Codes/PA:** Removed NMN denial from CPT 43285, allow to process according to terms of member benefits and eligibility.

REIMBURSEMENT POLICIES

Effective 7/1/24

Facility Routine Supplies and Services **RP43**	**Policy Updates:** Current policy doesn't allow separate payment for most nursing services. With this interim update, adding information to clarify our intent and what would be used to consider separate payment for nursing services. No other changes. **Reimbursement Methodology:** No change to current 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

Transfers Between Hospitals **RP75**	**Policy Updates:** No recommended changes to the reimbursement methodology for transfers. Continue to follow Medicare rules for commercial and Medicare members and OARs for OHP members. **Reimbursement Methodology:** No change to policy guidelines for the transferring hospitals reimbursement rate. • Commercial and Medicare: Transferring facility reimbursement=graduated per diem rate (if there is no specific transfer payment language in the facility contract). • OHP: Transferring facility reimbursement=based on OARs per diem interhospital transfer payment rate. • All LOBs: Full payment rate is made to the final discharging hospital. **Relevant References/CMS Guidance:** • 42 CFR § 412.4 – discharges and transfers. Legal Information Institute. https://www.law.cornell.edu/cfr/text/42/412.4. • Medicare Claims Processing Manual; Chapter 3 – Inpatient Hospital Billing. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf. Section 20.1.2.4 Transfers • Review of hospital compliance with Medicare's transfer policy. https://www.cms.gov/files/document/se21001.pdf. • OAR 410-125-0165 – Transfers and Reimbursement – Oregon Administrative Rules. https://oregon.public.law/rules/oar_410-125-0165.

Providence Health Plan

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Archive

Effective 7/1/24

Reimbursement Methodologies and All-Inclusive Rates **RP4**	**Policy Updates:** Previously a Coding Policy, but converted to a Reimbursement Policy in 2023. Review of policy revealed that it wasn't routinely being used and is predominately provider-contract based. It was determined the contents of this reimbursement policy could be transitioned to the Provider Reference Manual (PRM) for clarity, and then this reimbursement policy can be archived. **Reimbursement Methodology:** No change to current reimbursement methodology.

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

Pharmacy & Therapeutics (P&T) Committee

Oregon Region P&T Committee Meeting June 7, 2024
Go-Live Date: Thursday, August 01, 2024, unless otherwise noted

Special Announcements

Granulocyte-Colony Stimulating Factors (G-CSF's)
Effective 9/1/24, the health plan will be implementing a preferred product strategy for Granulocyte-Colony Stimulating Factors (G-CSF's) for all lines of business

- Neulasta® and Fulphila® will be preferred products and available without prior authorization
- All other products will be non-preferred and require prior authorization for coverage
    - Criteria for coverage will require use of the preferred products or sufficient medical rationale for not using the preferred products

Ophthalmic Vascular Endothelial Growth Factor (VEGF) Inhibitors
The health plan will be changing the preferred product strategy for VEGF inhibitor for all lines of business

- Lucentis® will be added as a preferred agent in parity with the biosimilars Byooviz® and Cimerli®; these will not require prior authorization
- The new product Eyelea HD® will be non-preferred and require prior authorization.

- Criteria for coverage will require use of the preferred products or sufficient medical rationale for not using the preferred products

Table of Contents:

New Drugs and Combinations:

1. **Exagamglogene autotemcel (Casgevy) Vial**
    1. **Indication**: For the treatment of sickle cell disease (SCD) in adult and pediatric patients ≥ 12 years of age with recurrent vaso-occlusive crises (VOCs) AND the treatment of transfusion-dependent beta-thalassemia (TDT) in adults and pediatric patients ≥ 12 years of age.
    2. **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	One administration per lifetime	One administration per lifetime	One administration per lifetime
* 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: For SCD: Oxbryta®, Adakveo®, Endari®, hydroxyurea. For TDT: Zynteglo®, Reblozyl®			

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

PA PROGRAM NAME	~~Zynteglo®~~ Gene Therapies for Hemoglobin Disorders
MEDICATION NAME	betibeglogene autotemcel (Zynteglo®) exagamglogene autotemcel (Casgevy®) lovotibeglogene autotemcel (Lyfgenia®)

PA INDICATION INDICATOR	1 – All FDA-Approved Indications
OFF-LABEL USES	N/A
EXCLUSION CRITERIA	N/A
REQUIRED MEDICAL INFORMATION	**For beta-thalassemia:** Zynteglo® or Casgevy® may be approved when all the following criteria are met: 1. Documented diagnosis of beta-thalassemia confirmed by genetic testing 2. Patient has transfusion-dependent disease defined as one of the following: a. History of transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs) b. Eight or more transfusions of pRBCs per year in the two years preceding therapy 3. Patient is clinically stable and eligible to undergo the pre-conditioning regimen and infusion regimen 4. Patient does not have any of the following: a. Prior history of receiving a hematopoietic stem-cell transplant b. Prior history of receiving gene therapy for the requested indication c. Advanced liver disease (such as evidence of cirrhosis and/or persistent alanine aminotransferase, aspartate transferase or direct bilirubin values greater than three times the upper limit of normal) ~~d. Evidence of severe iron overload (such as T2* less than 10 ms by magnetic resonance imaging (MRI) or other evidence of severe iron overload in the opinion of treating physician)~~ **For sickle cell disease:** Casgevy® or Lyfgenia® may be approved when all the following criteria are met: 1. Patient has a confirmed diagnosis of sickle cell disease with one of the following genotypes: ßS/ßS, ßS/ß0, ßS/ß+. The diagnosis may be confirmed with genetic testing results or provider attestation of genotype 2. Patient has experienced at least four vaso-occlusive events/crises (VOEs/VOCs) in the previous 24 months. A VOE/VOC is defined as an event requiring a visit to a medical facility for evaluation of acute pain, acute chest syndrome, acute splenic sequestration, acute hepatic sequestration, or priapism lasting greater than two hours 3. Patient is clinically stable and able to undergo the pre-infusion myeloablative chemotherapy regimen and gene therapy infusion regimen based on the assessment of the requesting provider 4. Documentation patient meets one of the following: a. Patient has experienced therapeutic failure of hydroxyurea despite use of a maximally tolerated dose for at least six months. Examples of therapeutic failure include incidence of one VOE/VOC or need for blood transfusion. b. Patient has had an intolerance or contraindication to hydroxyurea 5. Patient does not have any of the following: a. Prior history or receiving a hematopoietic stem-cell transplant b. Prior history of receiving gene therapy for the requested indication

	6. For Lyfgenia®: all the following additional criteria must be met: a. The patient has a contraindication to Casgevy® (exagamglogene autotemcel) b. The patient does not have disease with more than two alpha-globin gene deletions
AGE RESTRICTIONS	For Casgevy® and Lyfgenia®: May be approved for patients aged 12 years or older For Zynteglo®: May be approved for patients aged 4 years or older
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, a hematologist.
COVERAGE DURATION	Authorization will be limited to one treatment course per lifetime

2. **Lovotibeglogene autotemcel (Lyfgenia) Plast. Bag**
    1. **Indication**: For the treatment of sickle cell disease (SCD) in adults and pediatric patients ≥12 years of age with history of vaso-occlusive events (VOEs).
    2. **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	One administration per lifetime	One administration per lifetime	One administration per lifetime
* 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: Oxbryta®, Adakveo®, Endari®, hydroxyurea			

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

PA PROGRAM NAME	~~Zynteglo®~~ Gene Therapies for Hemoglobin Disorders
MEDICATION NAME	betibeglogene autotemcel (Zynteglo®) exagamglogene autotemcel (Casgevy®) lovotibeglogene autotemcel (Lyfgenia®)
PA INDICATION INDICATOR	1 – All FDA-Approved Indications
OFF-LABEL USES	N/A

EXCLUSION CRITERIA	N/A
REQUIRED MEDICAL INFORMATION	**For beta-thalassemia:** Zynteglo® or Casgevy® may be approved when all the following criteria are met: 1. Documented diagnosis of beta-thalassemia confirmed by genetic testing 2. Patient has transfusion-dependent disease defined as one of the following: c. History of transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs) d. Eight or more transfusions of pRBCs per year in the two years preceding therapy 3. Patient is clinically stable and eligible to undergo the pre-conditioning regimen and infusion regimen 4. Patient does not have any of the following: e. Prior history of receiving a hematopoietic stem-cell transplant f. Prior history of receiving gene therapy for the requested indication g. Advanced liver disease (such as evidence of cirrhosis and/or persistent alanine aminotransferase, aspartate transferase or direct bilirubin values greater than three times the upper limit of normal) ~~h. Evidence of severe iron overload (such as T2* less than 10 ms by magnetic resonance imaging (MRI) or other evidence of severe iron overload in the opinion of treating physician)~~ **For sickle cell disease:** Casgevy® or Lyfgenia® may be approved when all the following criteria are met: 1. Patient has a confirmed diagnosis of sickle cell disease with one of the following genotypes: ßS/ßS, ßS/ß0, ßS/ß+. The diagnosis may be confirmed with genetic testing results or provider attestation of genotype 2. Patient has experienced at least four vaso-occlusive events/crises (VOEs/VOCs) in the previous 24 months. A VOE/VOC is defined as an event requiring a visit to a medical facility for evaluation of acute pain, acute chest syndrome, acute splenic sequestration, acute hepatic sequestration, or priapism lasting greater than two hours 3. Patient is clinically stable and able to undergo the pre-infusion myeloablative chemotherapy regimen and gene therapy infusion regimen based on the assessment of the requesting provider 4. Documentation patient meets one of the following: a. Patient has experienced therapeutic failure of hydroxyurea despite use of a maximally tolerated dose for at least six months. Examples of therapeutic failure include incidence of one VOE/VOC or need for blood transfusion. b. Patient has had an intolerance or contraindication to hydroxyurea 5. Patient does not have any of the following: a. Prior history or receiving a hematopoietic stem-cell transplant b. Prior history of receiving gene therapy for the requested indication 6. For Lyfgenia®: all the following additional criteria must be met: a. The patient has a contraindication to Casgevy® (exagamglogene autotemcel) b. The patient does not have disease with more than two alpha-globin gene deletions

AGE RESTRICTIONS	For Casgevy® and Lyfgenia®: May be approved for patients aged 12 years or older For Zynteglo®: May be approved for patients aged 4 years or older
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, a hematologist.
COVERAGE DURATION	Authorization will be limited to one treatment course per lifetime

3. **Birch bark extract (Filsuvez) Gel (Gram)**

   a. **Indication**: For the treatment of wounds associated with dystrophic and junctional epidermolysis bullosa (DEB and JEB) in adult and pediatric patients 6 months 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	N/A
Quantity Limit	23.4 gram/day (1 single-use tube per day)	23.4 gram/day (1 single-use tube per day)	
* 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	Topical Agents for Epidermolysis Bullosa
MEDICATION NAME	Filsuvez
PA INDICATION INDICATOR	1 – All FDA-Approved Indications
OFF-LABEL USES	N/A
EXCLUSION CRITERIA	1. Skin graft within the past three months 2. Current evidence or a history of squamous cell carcinoma in the area(s) that will undergo treatment

	3. Combination therapy with Vyjuvek and Filsuvez
REQUIRED MEDICAL INFORMATION	Initial authorization requires all the following be met: 1. One of the following: a. For Vyjuvek: Diagnosis of dystrophic epidermolysis bullosa (EB) b. For Filsuvez: Diagnosis of dystrophic EB or junctional EB 2. Confirmed diagnosis by genetic testing. DEB is caused by mutations in the COL7A1 gene and JEB is caused by autosomal recessive mutations in the laminin-332 genes. 3. Treatment will be used on cutaneous wound(s) that are clean in appearance with adequate granulation tissue, excellent vascularization, and do not appear infected 4. Dosing is within FDA-labeled guidelines Reauthorization requires all the following be met: 1. Documentation of successful response to therapy as indicated by complete wound healing or decrease in wound size 2. Patient continues to have incomplete wound closures that are clean in appearance with adequate granulation tissue, excellent vascularization, and do not appear infected 3. Dosing is within FDA-labeled guidelines
AGE RESTRICTIONS	Approved according to FDA approved labeling
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, a dermatologist or provider with experience in treating epidermolysis bullosa
COVERAGE DURATION	Initial authorization: 3 months. Reauthorization: 1 year

4. **Budesonide (Eohilia) Susp Packt**
   a. **Indication**: For the treatment of inflammation in eosinophilic esophagitis.
   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	168 packets/365 days	168 packets/365 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: Proton pump inhibitors: esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole Topical glucocorticosteroid: budesonide nebulizer, fluticasone meter dose inhaler			

5. **Donislecel-jujn (Lantidra) Plast. Bag**

   a. **Indication**: For the treatment of adults with Type 1 diabetes who are unable to approach target HbA1c because of current repeated episodes of severe hypoglycemia despite intensive diabetes management and education. Use donislecel in conjunction with concomitant immunosuppression.

   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	3/lifetime	3/lifetime	3/lifetime
* 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/Medicare Part B**:

PA PROGRAM NAME	Lantidra
MEDICATION NAME	Lantidra
PA INDICATION INDICATOR	1 – All FDA-Approved Indications
OFF-LABEL USES	N/A
EXCLUSION CRITERIA	Pregnancy
REQUIRED MEDICAL INFORMATION	For initial authorization, all the following must be met: 1. Diagnosis of type 1 diabetes mellitus with a duration over five years

	2. Documentation of recurrent, acute, and severe metabolic and potentially life-threatening complications requiring medical attention, as documented by at least one emergency room visit and/or hospitalization in the previous 12 months due to one of the following: a. Hyperglycemia; or b. Hypoglycemia; or c. Hypoglycemia unawareness associated with high risk of injury; or d. Ketoacidosis 3. The patient has experienced hypoglycemia, defined as documentation of at least one of the following in the previous 12 months: a. Recurrent hypoglycemic events, [defined as glucose less than 54mg/dL (3.0mmol/L)] that persist despite multiple attempts to adjust medication(s) and/or modify the diabetes treatment plan b. History of one hypoglycemic event [defined as glucose less than 54mg/dL (3.0mmol/L)] characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia c. Documentation of hypoglycemic unawareness associated with high risk of injury d. History of ketoacidosis 4. Consistent failure of exogenous insulin-based management, defined as inability to achieve sufficient glycemic control (HbA1c >8%) or recurrent hypoglycemia unawareness, despite aggressive conventional therapy (usually including insulin pump), including all of the following: a. Adjusting frequencies and amounts of insulin injected; and b. Taking multiple blood glucose measurements on a daily basis; and. c. Modifying diet and exercise; and d. Monitoring HbA1c levels For reauthorization of second infusion or third infusion, 1. Documentation that the patient has not achieved independence from exogenous insulin within one of the following: a. within one year of donislecel infusion, or b. within one year after losing independence from exogenous insulin after a previous donislecel infusion 2. Documentation that the patient has received no more than three donislecel infusions per the patient's lifetime
AGE RESTRICTIONS	May be approved for patients aged 18 and older.
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, an endocrinologist or transplant surgeon with experience in islet cell transplantation

COVERAGE DURATION	Initial authorization will be approved for 12 months. Reauthorization will be approved for 12 months.

6. **Eplontersen sodium (Wainua) Auto Inject**
   a. **Indication**: For the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR-PN) in adults.
   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary	Formulary	Part D: Non-formulary Part B: N/A
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	N/A
Quantity Limit	One 45-mg syringe/30 days	One 45-mg syringe/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: Tegsedi			

   c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Transthyretin (TTR) Lowering Agents policy

7. **Etrasimod arginine (Velsipity) Tablet**
   a. **Indication**: For the treatment of moderately to severely active ulcerative colitis 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	Prior Authorization	Prior Authorization	N/A
Quantity Limit	1 tablet/day	1 tablet/day	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: Zeposia, adalimumab, Xeljanz, Rinvoq, Entyvio, Stelara, Simponi,

c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Therapeutic Immunomodulators (TIMs) Policy as non-preferred.

8. **Iptacopan hcl (Fabhalta) Capsule**

a. **Indication**: For the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH).

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	Tier 6 – Non-Preferred Specialty	N/A	
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	N/A
Quantity Limit	2 capsules/day	2 capsules/day	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:			

c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Complement Inhibitor policy in parity with Soliris®.

9. **Lifileucel (Amtagvi) Plast. Bag**

a. **Indication**: For the treatment of adult patients with unresectable or metastatic melanoma previously treated with a PD-1 blocking antibody and if BRAF V600 mutation positive, a BRAF inhibitor with or without a MEK inhibitor. Also known as tumor-infiltrating lymphocyte (TIL) therapy.

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: nivolumab (Opdivo), pembrolizumab (Keytruda), nivolumab/relatilimab (Opdualag)			

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

PA PROGRAM NAME	T-cell therapy
MEDICATION NAME	Lifileucel (Amtagvi)
PA INDICATION INDICATOR	1 – All FDA-Approved Indications
EXCLUSION CRITERIA	For Amtagvi: Previous treatment with Amtagvi therapy. Repeat administration is not considered medically necessary as the effectiveness of this approach has not been established.
REQUIRED MEDICAL INFORMATION	For all requests, the following criteria must be met: 1. Use must be for an indication supported by National Comprehensive Cancer Network (NCCN) guidelines with recommendation 2A or higher 2. Documentation of adequate bone marrow, cardiac, pulmonary and organ function (such as kidney, liver) 3. Provider attestation/documentation that the patient's functional status is sufficient to undergo treatment. This may include but is not limited to a documented Eastern Cooperative Oncology Group (ECOG) performance status of 0-1 or a written statement acknowledging that the patient is fit to tolerate therapy. 4. No evidence of active infection or inflammatory disorder (including hepatitis B or C, active graft vs. host disease)
AGE RESTRICTIONS	Age must be appropriate based on FDA-approved indication
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, an oncologist
COVERAGE DURATION	For chimeric antigen receptor (CAR) T-cell therapy and Amtagvi: Two months (limited to one treatment course per lifetime, with four doses of tocilizumab [Actemra®] at up to 800 mg per dose).

10. **Mirikizumab-mrkz (Omvoh) Pen Injctr – Vial**

a. **Indication**: For the treatment of moderately to severely active ulcerative colitis 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	Prior Authorization	Prior Authorization	N/A
Quantity Limit	2 pens/28 days	2 pens/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: Zeposia, adalimumab, Xeljanz, Rinvoq, Entyvio, Stelara, Simponi, infliximab			

c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Therapeutic Immunomodulators (TIMs) Policy as non-preferred.

11. **Nedosiran sodium (Rivfloza) Syringe-Vial**

a. **Indication**: To lower urinary oxalate levels in children 9 years of age and older and adults with primary hyperoxaluria type 1 (PH1) and relatively preserved kidney function, e.g., eGFR ≥ 30 mL/min/1.73 m^2.

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: N/A			

c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Hyperoxaluria Agents policy

12. **Taurolidine in heparin sodium (Defencath) Vial**

a. **Indication**: To reduce the incidence of catheter-related bloodstream infections (CRBSI) in adult patients with kidney failure receiving chronic hemodialysis (HD) through a central venous catheter (CVC).

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	N/A	N/A	N/A
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: N/A			

13. **Travoprost (Idose TR) Implant**

a. **Indication**: For the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OHT).

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: latanoprost, bimatoprost, Travoprost, tafluprost, Vyzulta, Lumigan, Zioptan, Iyuzeh, Rhopressa ophthalmic drops			

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

PA PROGRAM NAME	~~Durysta®~~ Ophthalmic Prostaglandin Implants
MEDICATION NAME	Travoprost intracameral implant (iDose TR®)

PA INDICATION INDICATOR	1 – All FDA-Approved Indications
OFF-LABEL USES	None
EXCLUSION CRITERIA	N/A
REQUIRED MEDICAL INFORMATION	The following criteria must be met: 1. The patient is not receiving re-treatment of eye(s) previously treated with ~~bimatoprost intracameral implant (Durysta®)~~ the requested therapy 2. Trial and failure, intolerance or contraindication to at least two ophthalmic products (either as monotherapy or as concomitant therapy) from two different pharmacological classes, one of which is an ophthalmic prostaglandin (for example, bimatoprost, latanoprost, or travoprost)
AGE RESTRICTIONS	Approved for 18 years and older
PRESCRIBER RESTRICTIONS	Must be prescribed by an ophthalmologist
COVERAGE DURATION	Authorization will be approved for six months. Approval will be for a one-time use in each treated eye (one implant per treated eye, a total of two implants per patient)

14. **Vamorolone (Agamree) Oral Susp**

a. **Indication**: For the treatment of Duchenne muscular dystrophy (DMD) in patients aged two 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	N/A
Quantity Limit	7.5 mL (300 mg) per day	7.5 mL (300 mg) per day	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: Prednisone, deflazacort (Emflaza)			

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

PA PROGRAM NAME	~~Emflaza,~~ Corticosteroids for Duchenne Muscular Dystrophy
MEDICATION NAME	Vamorolone (Agamree) oral suspension
PA INDICATION INDICATOR	1 – All FDA-Approved Indications
OFF-LABEL USES	N/A

EXCLUSION CRITERIA	N/A
REQUIRED MEDICAL INFORMATION	Initial authorization: 1. Confirmed diagnosis of Duchenne Muscular Dystrophy by genetic testing (prescriber must provide genetic test to confirm diagnosis) 2. Documentation of one of the following: a. The patient has tried prednisone for at least six months and has experienced one of the following clinically significant adverse events: cushingoid appearance, central (truncal obesity), weight gain of at least 10% body weight over a 6-month period or diabetes and/or hypertension that is difficult to manage according to the prescribing physician OR b. The patient has tried prednisone and has experienced psychiatric/behavioral issues (such as abnormal behavior, aggression, or irritability) i. The psychiatric/behavioral issues persisted beyond the first six weeks of treatment with prednisone AND ii. A change in timing of prednisone administration (such as changing from morning to evening) has been attempted but was unsuccessful in resolving issues 3. For Agamree: Documentation of inadequate response (after at least three months of therapy), clinically significant adverse events (such as cataracts, growth delay, reduced bone density or bone fractures), or contraindication to deflazacort 4. The dose requested is within FDA labeled dosing based on the patient's weight (patient's weight must be provided) AND dose is given in most cost effective manner (such as rounding to appropriate tablet strength or use of suspension) Re-authorization: 1. Documentation of clinical benefit from therapy, such as improvement or stabilization of muscle strength or pulmonary function 2. The dose requested is within FDA labeled dosing based on the patient's weight (updated weight must be provided) AND dose is given in most cost effective manner (such as rounding to appropriate tablet strength or use of suspension)
AGE RESTRICTIONS	Two years of age and older
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with a provider that specializes in the treatment of Duchenne muscular dystrophy (DMD) and/or neuromuscular disorders
COVERAGE DURATION	Initial authorization and reauthorization will be approved for one year.

15. **Zilucoplan sodium (Zilbrysq) Syringe**
    a. **Indication**: For the treatment of adult patients with generalized myasthenia gravis (gMG).

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: N/A			

c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to Complement Inhibitors Policy

New Indications:

Therapies with Prior Authorization Policies (Non-oncology)

1. **Xolair** (omalizumab)
    a. Previous Indication(s):
        a. Moderate to severe persistent asthma in adults and pediatric patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids
        b. Chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as add-on maintenance treatment
        c. Chronic spontaneous urticaria (CSU) in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment
    b. New indication approved 02/16/2024:
        a. IgE-mediated food allergy in adult and pediatric patients aged 1 year and older for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods. To be used in conjunction with food allergen avoidance
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Policies are being updated as part of June P&T annual policy updates and will include review of this indication.

2. **Praluent** (alirocumab)
    a. Previous Indication(s):
        a. To reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established cardiovascular disease
        b. As adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-C)-lowering therapies, in adults with primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH), to reduce LDL-C
        c. As an adjunct to other LDL-C-lowering therapies in adult patients with homozygous familial hypercholesterolemia (HoFH) to reduce LDL-C
    b. New indication approved 03/08/2024:
        a. As an adjunct to diet and other LDL-C-lowering therapies in pediatric patients aged 8 years and older with HeFH to reduce LDL-C
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Policies are being updated as part of June P&T annual policy updates and will include review of this indication.

3. **Spevigo** (spesolimab-SBZO)
    a. Previous Indication(s):
        a. Indicated for the treatment of generalized pustular psoriasis flares in adults
    b. New indication approved 03/18/2024:
        a. Indicated for the treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older and weighing at least 40 kg
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Policies will be updated as part of August P&T annual review

4. **Ultomiris** (ravulizumab-cwvz)
    a. Previous Indication(s):
        a. The treatment of adult and pediatric patients one month of age and older with paroxysmal nocturnal hemoglobinuria (PNH)
        b. The treatment of adult and pediatric patients one month of age and older with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA)
        c. The treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AchR) antibody-positive
    b. New indication approved 03/22/2024:
        a. The treatment of adult patients with neuromyelitis optica spectrum disorder (NMOSD) who are anti-aquaporin-4 (AQP4) antibody positive
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Policies are being updated as part of June P&T annual policy updates and will include review of this indication.

5. **Livmarli** (maralixibat chloride)
    a. Previous Indication(s):
        a. Indicated for the treatment of cholestatic pruritus in patients with Alagille syndrome (ALGS) 3 months of age and older
    b. New indication approved 03/13/2024:
        a. Indicated the treatment of cholestatic pruritus in patients 5 years of age and older with progressive familial intrahepatic cholestasis (PFIC)
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Update policy with new indication and policy criteria.

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

PA PROGRAM NAME	Cholestatic Pruritus Agents
PA INDICATION INDICATOR	1 – All FDA-Approved Indications
REQUIRED MEDICAL INFORMATION	c. For Progressive Familial Intrahepatic Cholestasis (PFIC): i. Documentation of genetically confirmed PFIC type 1 or 2 (formerly known as Byler disease or syndrome) (note: gene mutations affiliated with PFIC include the ATP8B1 gene, ABCB11 gene, ABCB4 gene, TJP2 gene, NR1H4 gene, and MYO5B gene) AND ii. For Livmarli®: Documentation that total serum bile acid is greater than three times ULN for age iii. For Bylvay®: Documentation that serum bile acids at least 100 micromol/L
AGE RESTRICTION	The patient's age must be within FDA labeling for the requested indication

6. **Xhance** (fluticasone propionate)
    a. Previous Indication(s):
        a. Indicated for the treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age or older
    b. New indication approved 03/15/2024:
        a. Indicated for the treatment of:
            1. Chronic rhinosinusitis with nasal polyps (CRSwNP) in adults
            2. Chronic rhinosinusitis without nasal polyps (CRSsNP) in adults
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Policies are being updated as part of June P&T annual policy updates and will include review of this indication.

7. **Nexletol; Nexlizet** (bempedoic acid; bempedoic acid and ezetimibe)
    a. Previous Indication(s):
        a. Indicated as an adjunct to diet and statin therapy for the treatment of primary hyperlipidemia in adults with heterozygous familial hypercholesterolemia (HeFH) or atherosclerotic cardiovascular disease, who require additional lowering of LDL-C
    b. New indication approved 03/22/2024:
        a. To reduce the risk of myocardial infarction and coronary revascularization in adults who are unable to take recommended statin therapy (including those not taking a statin) with:
            1. established cardiovascular disease (CVD), or
            2. a high risk for a CVD event but without established CVD
        b. As an adjunct to diet, in combination with other low-density lipoprotein cholesterol (LDL-C) lowering therapies, or alone when concomitant LDL-C lowering therapy is not possible, to reduce LDL-C in adults with primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH)
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert. Policies are being updated as part of June P&T annual policy updates and will include review of this indication.

Therapies with Prior Authorization Policies (Oncology)

1. **Rybrevant** (amivantamab-vmjw)
    a. New indication(s) approved 3/1/2024:

i. In combination with carboplatin and pemetrexed for the first-line treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations, as detected by an FDA-approved test

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. **Onivyde** (irinotecan liposome injection)
   a. New indication(s) approved 2/13/2024:
      i. In combination with oxaliplatin, fluorouracil and leucovorin, for the first-line treatment of adult patients with metastatic pancreatic adenocarcinoma
   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. **Tagrisso** (osimertinib)
   a. New indication(s) approved 2/16/2024:
      i. In combination with pemetrexed and platinum-based chemotherapy, the first-line treatment of adult patients with locally advanced or metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test
   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. **Opdivo** (nivolumab)
   a. New indication(s) approved 03/06/2024:
      i. Urothelial Carcinoma
         - Adult patients with unresectable or metastatic urothelial carcinoma, as firstline treatment in combination with cisplatin and gemcitabine
   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. **Besponsa** (inotuzumab ozogamicin)
   a. New indication(s) approved 03/06/2024:
      i. Treatment of relapsed or refractory CD22-positive B-cell precursor acute lymphoblastic leukemia (ALL) in adult and pediatric patients 1 year and older
   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.

6. **Brukinsa** (zanubrutinib)
   a. New indication(s) approved 03/07/2024:
      i. Relapsed or refractory follicular lymphoma (FL), in combination with obinutuzumab, after two or more lines of systemic therapy. This indication is approved under accelerated approval based on response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial

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.

7. **Iclusig** (ponatinib)
   a. New indication(s) approved 03/19/2024:
      i. Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ ALL):
         - Newly diagnosed Ph+ ALL, in combination with chemotherapy. This indication is approved under accelerated approval based on minimal residual disease (MRD)-negative complete remission (CR) at the end of induction. Continued approval for this indication may be contingent upon verification of clinical benefit in a confirmatory trial(s)
         - As monotherapy in Ph+ ALL for whom no other kinase inhibitors are indicated or T315I-positive Ph+ ALL

      ii. Chronic Myeloid Leukemia (CML):
         - Chronic phase (CP) CML with resistance or intolerance to at least two prior kinase inhibitors
         - Accelerated phase (AP) or blast phase (BP) CML for whom no other kinase inhibitors are indicated
         - T315I-positive CML (chronic phase, accelerated phase, or blast phase)

      Limitations of Use: ICLUSIG is not indicated and is not recommended for the treatment of patients with newly diagnosed CP-CML
   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.

Therapies Without Prior Authorization Policies

1. **Creon, Pertzye, Zenpep, Pancreaze** (pancrelipase)
   a. Previous Indication(s):
      i. Indicated for the treatment of exocrine pancreatic insufficiency due to cystic fibrosis, chronic pancreatitis, pancreatectomy, or other conditions
   b. New indication approved 02/28/2024:
      i. Indicated for the treatment of exocrine pancreatic insufficiency in adult and pediatric patients
   c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert.

2. **Ziextenzo** (pegfilgrastim-bmez)
   a. Previous Indication(s):
      i. Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia
   b. New indication approved 02/28/2024:
      i. Increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome)
   c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert.

3. **Cefazolin In Plastic Container**
   a. Previous Indication(s):

i. Treatment of the following infections caused by susceptible isolates of the designated microorganisms in adult and pediatric patients for whom appropriate dosing with this formulation can be achieved:
   1. Respiratory tract infections
   2. Urinary tract infections
   3. Skin and skin structure infections
   4. Biliary tract infections
   5. Bone and joint infections
   6. Genital infections
   7. Septicemia
   8. Endocarditis

ii. Perioperative prophylaxis in adults for whom appropriate dosing with this formulation can be achieved

b. New indication approved 02/01/2024:
   i. Perioperative prophylaxis in adults and pediatric patients aged 10 to 17 years old for whom appropriate dosing with this formulation can be achieved

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

4. **Biktarvy** (bictegravir, emtricitabine, tenofovir alafenamide)
   a. Previous Indication(s):
      i. Indicated as a complete regimen for the treatment of HIV-1 infection in adults and pediatric patients weighing at least 14 kg who have no antiretroviral treatment history or to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of treatment failure and no known substitutions associated with resistance to the individual components of BIKTARVY
   b. New indication approved 02/23/2024:
      i. Indicated as a complete regimen for the treatment of HIV-1 infection in adults and pediatric patients weighing at least 14 kg:
         1. who have no antiretroviral treatment history or
         2. to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no known or suspected substitutions associated with resistance to bictegravir or tenofovir
   c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert.

5. **Veklury** (remdesivir)
   a. Previous Indication(s):
      i. Indicated for the treatment of coronavirus disease 2019 (COVID-19) in adults and pediatric patients (28 days of age and older and weighing at least 3 kg) who are:
         1. Hospitalized, or
         2. Not hospitalized and have mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death
   b. New indication approved 02/23/2024:

i. Indicated for the treatment of coronavirus disease 2019 (COVID-19) in adults and pediatric patients (birth to less than 18 years of age weighing at least 1.5 kg) who are:
    1. Hospitalized, or
    2. Not hospitalized and have mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death

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

6. **Definity** (perflutren lipid microsphere)
    a. Previous Indication(s):
        i. Indicated for use in patients with suboptimal echocardiograms to opacify the left ventricular chamber and to improve the delineation of the left ventricular endocardial border
    b. New indication approved 03/01/2024:
        i. Indicated, after activation, for use in adult and pediatric patients with suboptimal echocardiograms to opacify the left ventricular chamber and to improve the delineation of the left ventricular endocardial border
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert.

7. **Xofluza** (baloxavir marboxil)
    a. Previous Indication(s):
        i. Treatment of acute uncomplicated influenza in patients who have been symptomatic for no more than 48 hours and who are:
            1. otherwise healthy adults and pediatric patients 5 years of age and older
                OR
            2. adults and pediatric patients 12 years of age and older who are at highrisk of developing influenza-related complications
        ii. Post-exposure prophylaxis of influenza in patients 5 years of age and older following contact with an individual who has influenza
    b. New indication approved 03/01/2024:
        i. Treatment of acute uncomplicated influenza in patients 5 years of age and older who have been symptomatic for no more than 48 hours and who are otherwise healthy or at high risk of developing influenza-related complications
    c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert.

8. **Edurant** (rilpivirine)
    a. Previous Indication(s):
        i. Indicated in combination with other antiretroviral agents for the treatment of HIV-1 infection in treatment-naïve patients 12 years of age and older and weighing at least 35 kg with HIV-1 RNA less than or equal to 100,000 copies/mL
            1. Limitation of Use:
                a. More EDURANT treated subjects with HIV-1 RNA greater than 100,000 copies/mL at the start of therapy experienced virologic failure (HIV-1 RNA ≥50 copies/mL) compared to EDURANT treated subjects with HIV-1 RNA less than or equal to 100,000 copies/mL

   ii. Indicated in combination with VOCABRIA (cabotegravir), for short-term treatment of HIV-1 infection in adults and adolescents 12 years and older and weighing at least 35 kg who are virologically suppressed (HIV-1 RNA less than 50 copies/mL) on a stable regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine

b. New indication approved 03/01/2024:
   i. Indicated in combination with other antiretroviral agents for the treatment of HIV-1 infection in treatment-naïve patients **2 years of age** and older and weighing at least **14 kg** with HIV-1 RNA less than or equal to 100,000 copies/mL

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

9. **Vemlidy** (tenofovir alafenamide)
   a. Previous Indication(s):
      i. Indicated for the treatment of chronic hepatitis B virus infection in adults and pediatric patients 12 years of age and older with compensated liver disease
   b. New indication approved 03/27/2024:
      i. Indicated for the treatment of chronic hepatitis B virus infection in adults and pediatric patients 6 years of age and older and weighing at least 25 kg with compensated liver disease
   c. **RECOMMENDATION:** Inform prescribers via Medical Policy Alert.

Drug Safety Monitoring:

FDA Drug Safety Communications

There were no drug safety communications reported during this period.

Drug Recalls/Market Withdrawals

1. **Drug Name:** TING® 1% Tolnaftate Athlete's Foot Spray Antifungal Spray Liquid
   - **Date of Recall:** 2/2/2024
   - **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-tingr-1-tolnaftate-athletes-foot-spray
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

2. **Drug Name:** Arize brand male enhancement capsules
   - **Date of Recall:** 2/5/2024

- **Reason for recall:** Products contain undeclared Nortadalafil
- **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/today-world-issues-voluntary-nationwide-recall-all-lots-arize-herbal-dietary-supplement-capsules-due
- **Health Plan Recommendation:** Notify providers via Medical Policy Alert

3. **Drug Name:** Sustain and Schwinnng brand male enhancement capsules
   - **Date of Recall:** 2/5/2024
   - **Reason for recall:** Products contain undeclared Tadalafil and Nortadalafil
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/today-world-issues-voluntary-nationwide-recall-all-lots-sustain-and-schwinnng-brand-dietary
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

4. **Drug Name:** Equate Lubricant Eye Ointment (Mineral Oil 42.5%, White Petrolatum 57.3%, Lanolin Alcohols), Equate Stye Lubricant Eye Ointment (Mineral Oil 31.9%, White Petrolatum 57.7%, Microcrystalline Wax, Stearic Acid, Wheat Germ Oil), CVS Health Lubricant Eye Ointment (Mineral Oil 31.9%, White Petrolatum 57.7%, Microcrystalline Wax, Stearic Acid Wheat Germ Oil, Lubricant PM Ointment
   - **Date of Recall:** 2/26/2024
   - **Reason for recall:** Due to Potential Lack of Sterility Assurance
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/brassica-pharma-pvt-ltd-issues-voluntary-nationwide-recall-equate-lubricant-eye-ointment-equate-stye
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

5. **Drug Name:** Par Pharmaceutical Treprostinil 20mg/20mL Injection
   - **Date of Recall:** 3/12/2024
   - **Reason for recall:** Potential Presence of Silicone Particulate Matter
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/par-pharmaceutical-issues-voluntary-nationwide-recall-one-lot-treprostinil-injection-due-potential
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

6. **Drug Name:** Pyramid Wholesale dietary supplements for sexual enhancement (multiple brands)
   - **Date of Recall:** 3/20/2024
   - **Reason for recall:** Undeclared Sildenafil and/or Tadalafil
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/pyramid-wholesale-issues-recall-various-brands-products-sold-dietary-supplements-sexual-enhancement
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

7. **Drug Name:** Amneal Vancomycin Hydrochloride for Oral Solution, USP, 250 mg/5mL

- **Date of Recall:** 3/27/2024
- **Reason for recall:** Super potent due to bottles being overfilled
- **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/amneal-pharmaceuticals-llc-issues-nationwide-voluntary-recall-vancomycin-hydrochloride-oral-solution
- **Health Plan Recommendation:** Notify providers via Medical Policy Alert

8. **Drug Name:** Eugia brand Methocarbamol Injection, USP 1000 mg/10 mL (100mg/mL) (Single Dose Vial)
   - **Date of Recall:** 3/28/2024
   - **Reason for recall:** Device & Drug Safety – Presence of Particulate Matter
   - **Link to more information:** https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/eugia-us-llc-fka-auromedics-pharma-llc-issues-voluntary-nationwide-recall-methocarbamol-injection
   - **Health Plan Recommendation:** Notify providers via Medical Policy Alert

Other Formulary Changes:

Drug Name	Action Taken	Policy Name
Palovarotene (Sohonos) Capsule	Correction from April 2024 P&T: • Medicare Part D: Non-Formulary without Prior Authorization	N/A
Tiopronin Tablet DR	First generic drug (Thiola EC). Line extend as generic; • Commercial: Formulary, Tier 6 • Medicaid: Non-Formulary, Specialty • Medicare Part D: Non-Formulary	N/A
Apomorphine hcl Cartridge	Add to Commercial Formulary, Tier 5	N/A
Fesoterodine fumarate Tab ER 24h	Add to Commercial Formulary; • Commercial Standard: Tier 2 • Commercial Dynamic: Tier 4	N/A
Testosterone undecanoate (Kyzatrex) Capsule	Remove from Commercial and Medicaid formularies Effective 09/01/2024	N/A
• **Nirsevimab-alip (Beyfortus)** • **Palivizumab (Synagis)**	Remains covered medical benefit for all lines of business	N/A
Nevirapine Oral Susp	Add to Commercial Formulary;	N/A

Drug Name	Action Taken	Policy Name
	Commercial Standard: Tier 2 Commercial Dynamic: Tier 4	
Secukinumab (Cosentyx) Vial	New strength (125mg/5ml), dosage form (vial) and route (Intravenous); • Medical Benefit, Prior Authorization for all lines of business	• Commercial: Medically Infused Therapeutic Immunomodulators (Tims) – Comm • Medicaid: Therapeutic Immunomodulators (TIMS) – Medicaid • Medicare Part B: Medically Infused Therapeutic Immunomodulators (TIMs) Prior Authorization and Step Therapy Policy – Medicare Part B
Vedolizumab (Entyvio Pen) Pen Injctr	New route (subcutaneous), strength (108mg/0.68ml), and dosage Form (Pen Injctr); • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1.36 mL per 28 days) • Medicare Part D: Non-Formulary	• Commercial/Medicaid: Therapeutic Immunomodulators • Medicare Part D: N/A
Tramadol hcl Tablet	New strength (25mg); • Non-Formulary for all lines of business	N/A
Sitagliptin (Zituvio) Tablet	New authorized generic (Januvia); • Commercial: Non-Formulary, Step Therapy • Medicaid: Non-Formulary, Step Therapy • Medicare Part D: Non-Formulary	• Commercial/Medicaid: DPP-4 Inhibitors • Medicare Part D: N/A
Bepotastine besilate (Bepreve) Drops	Remove from Commercial formulary	N/A
Cetirizine hcl (Zerviate) Droperette	Remove from Commercial formulary	N/A
Auvi-Q, Epipen, Epipen Jr, Symjepi	• Commercial/Medicaid: Increase quantity limit to 4 pens (2 packs of 2) per 90 days	N/A
Pirfenidone 267 mg Capsule	Add to formulary:	Esbriet, Ofev, Pirfenidone tablets

Drug Name	Action Taken	Policy Name
	• Commercial: Formulary, Tier 5, Prior Authorization, Quantity Limit (6 capsules per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (6 capsules per day)	
Pirfenidone (Esbriet) 267 mg and 534 mg Tablets	Remove from Commercial and Medicaid Formulary Effective 09/01/2024	Esbriet, Ofev, Pirfenidone tablets
• **Sitagliptin (Januvia) Tablet** • **Sitagliptin/metformin (Janumet/Janumet XR) Tablet**	Commercial: Move to Tier 3 from Tier 4	DPP-4 Inhibitors
• **Bempedoic acid (Nexletol) Tablet** • **Bempedoic acid/ezetimibe (Nexlizet) Tablet**	• Commercial: Add to Formulary, Tier 4 • Medicaid: Add to Formulary	Nexletol, Nexlizet
Mepolizumab (Nucala) Auto Injct / Syringe	Add to Medicaid formulary	IL-5 Inhibitors
Mepolizumab (Nucala) Vial	Remove from Commercial and Medicaid formulary (covered under the medical benefit with prior authorization)	IL-5 Inhibitors
• **Ciclesonide (Omnaris) Spray/Pump** • **Beclomethasone dipropionate (Qnasl) Spray** • **Ciclesonide (Zetonna) Spray**	Remove from Commercial formulary	N/A
• **Flunisolide (36asalide) 0.025% nasal spray** • **Mometasone (Nasonex) 50 mcg nasal spray**	Commercial Dynamic: Move to Tier 2 from Tier 3	N/A
Dapagliflozin Tablet	Authorized generic (Farxiga). • Commercial: Non-Formulary	N/A

Drug Name	Action Taken	Policy Name
	• Medicaid: Formulary • Medicare Part D: Non-Formulary, Quantity Limit (1 tablet per day)	
• **Novolog/Novolog Mix** • **Novolin R, N, 70/30** • **Fiasp**	Added to Commercial Formulary, Tier 3 Effective 07/01/2024	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**
Pemetrexed disodium (Pemrydi RTU) Vial	New entity. Line extend as covered medical benefit for all lines of business	N/A
Nirogacestat hydrobromide (Ogsiveo) Tablet	New strength. Line extend with Ogsiveo 50mg tablet; • Commercial: Formulary, Tier 6, Prior Authorization • Medicaid: Formulary, Prior Authorization • Medicare Part D: Formulary, Tier 5, Prior Authorization	Anti-Cancer Medications – Self-Administered
Emicizumab-kxwh (Hemlibra) Vial	New strength. Line extend with other Hemlibra; • Commercial/Medicaid: Medical Prior Authorization • Medicare Part D: Non-Formulary • Medicare Part B: Prior Authorization	Hemlibra

NEW GENERICS		
Drug Name	**Action Taken**	**Policy Name**
Nitroglycerin Oint.	First generic drug (Rectiv). Line extend as generic; • Commercial Standard: Formulary, Tier 2 • Commercial Dynamic: Formulary, Tier 4 • Medicaid: Non-Formulary • Medicare Part D: Formulary, Tier 4	N/A
Citric acid/sodium citrate (Oral Citrate) Solution	First generic drug (Oracit). Line extend as generic; • Non-Formulary for all lines of business	N/A
Carbinoxamine Maleate Tablet	First generic drug (Ryvent). Line extend as generic; • 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
Adalimumab-ryvk (Adalimumab-RYVK [CF]) Autoinjkit and Syringekit	New Humira biosimilar. Line extend with non-preferred Humira biosimilars; • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 syringe kit per 28 days) • Medicare Part D: Non-Formulary	Therapeutic Immunomodulators (TIMS)
Adalimumab-aaty (Yuflyma [CF]) Syringekit	New BLA: Line extend with other Yuflyma; • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 syringe kit per 28 days), Specialty • Medicare Part D: Non-Formulary	Therapeutic Immunomodulators (TIMS)

MAJOR CHANGES	
Policy Name	**Summary of Change**
Actinic Keratosis Agents	Remove prior authorization on fluorouracil 4% cream (Tolak®) and removed prescriber restriction for treatment of genital warts.
Adbry	For Commercial: Removed daily/twice daily application requirement for topicals For Medicaid: Clarified members needs trial of four weeks of prerequisite therapy.
Benlysta	Simplified diagnostic criteria and updated prerequisite therapies based on the latest guideline updates. Removed the requirement to use standard therapy in reauthorization criteria based on provider feedback.
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists	Removed exclusion of combination therapy for acute treatments, as the risk of exacerbating medication overuse headache has not been well established with CGRPs. This criterion has caused a lot of operational burden and member/provider dissatisfaction.
Camzyos	Removed requirement for providing documentation/imaging to support diagnosis. Updated conventional therapy based on guideline recommendations.
Cibinqo	For Commercial: Updated requirement of trial of upadacitinib (Rinvoq®) to dupilumab (Dupixent®) and removed daily/twice daily application requirement for topicals For Medicaid: Clarified members needs trial of four (4) weeks of prerequisite therapy.
• **Complement Inhibitors** • **Complement Inhibitors Prior Authorization and Step Therapy Policy – Medicare Part B**	New policy combining criteria for Soliris®, Ultomiris®, and Empaveli®. Aligned criteria for all agents, updated exclusion to not allow with another complement inhibitor OR an Fc receptor antagonist. Soliris® will required use of more cost-effective agents for overlapping indications.
Corlanor	Clarified definition of inappropriate sinus tachycardia and that postural orthostatic tachycardia syndrome should be ruled out. Slightly reworded crtieria for guideline directed medical therapy (intent did not change).
Denavir, Sitavig, Xerese, Zovirax	Retired prior authorization on acyclovir 5% ointment. Removed references to Sitavig®, as this drug is no longer available on the market.
DPP-4 Inhibitors	Changed policy to a step therapy policy; claims for non-preferred therapies will require trial of saxagliptin or alogliptin for coverage.

Esbriet, Ofev, Pirfenidone tablets	Remove brand Esbriet and pirfenidone 267 mg and 534 tablets, as these drugs are non-preferred behind the pirfenidone 267 mg capsules.
Granulocyte-Colony Stimulating Factor (G-CSF) Policy	New policy and preferred product strategy. Preferred pegfilgrastim products (Neulasta® and Fulphila®) will continue to be available without prior authorization. Non-preferred products will require prior authorization and use of preferred products. Effective 09/01/2024
• **Homozygous Familial Hypercholesterolemia (FH) Agents** • **Homozygous FH Agents – Medicare Part B**	Updated policy language clarify dosage range for defining high-intensity statins.
• **IL-5 Inhibitors** • **Il-5 Inhibitors Prior Authorization and Step Therapy – Medicare Part B**	Updated diagnostic criteria to remove lab values measured while patient on high doses of steroids or oral steroids as it is presumed that eosinophilic level would be lower if on steroids.
Intranasal Allergy Medications – Medicaid	Xhance was added to the policy and language around covered diagnosis was clarified.
Medications for Rare Indications	Policy criteria for urea cycle disorders was updated to require use of Pheburane® (sodium phenylbutyrate pellets) prior to coverage of Ravicti® or Olpruva®
Nexletol, Nexlizet	1. Added new indication of cardiovascular risk reduction in both primary and secondary prevention, 2. Removed PCSK-9 inhibitors as a prerequisite, 3. Re-worded statin intolerance definition to align with our other policies such as PCSK-9 inhibitors.
• **Ophthalmic Vascular Endothelial Growth Factor (VEGF) Inhibitors** • **Ophthalmic VEGF Inhibitors Prior Authorization and Step Therapy Policy – Medicare Part B**	Changed preferred product strategy. Eyelea HD® will be non-preferred and Lucentis® (along with biosimilars Byooviz® and Cimerli®) will be preferred for the respective indications. Preferred agents do not require prior authorization.
Oxervate	Reduced number of required failed conventional therapies.
• **PCSK9 Inhibitors – Commercial** • **PCSK9 Inhibitors – Medicaid**	Updated age restriction criteria and new indication for Praluent.
Pulmonary Hypertension	Clarified that pulmonary capillary wedge pressure/left ventricular end diastolic pressure is used for diagnosis of pulmonary arterial hypertension or WHO group 1 only. Removed criteria for brand Tracleer tablets and Letairis as these are reviewed using the brand

	over generic policy. Added exclusion of idiopathic pulmonary fibrosis for ambrisentan due to contraindication in package insert.
Pulmonary Hypertension Prior Authorization Policy – Medicare Part B	Clarified that pulmonary capillary wedge pressure/left ventricular end diastolic pressure is used for diagnosis of pulmonary arterial hypertension or WHO group 1 only.
Second and Third Generation Antihistamines – Medicaid	Updated criteria to add comorbid conditions for patients under age 21 to align with Oregon Health Authority.
Syfovre	Rename policy to Geographic Atrophy Agents and add Izervay.
Tafamidis	Clarified the need for documentation of New York Heart Association class. Updated concurrent drug exclusion criteria to include the two new drugs for transthyretin-mediated amyloidosis polyneuropathy.
Tezspire	Clarified that coverage of medication when being administered by a healthcare provider would only be approved for short duration, as this medication is required to be self-administered. Clarified prescriber restrictions apply for initial and subsequent authorizations.
Tezspire – Medicare Part B	Clarified prescriber restrictions apply for initial and subsequent authorizations.
• **Therapeutic Immunomodulators** • **Therapeutic Immunomodulators – Medicaid**	Added criteria for new self-administered vedolizumab (Entyvio®) product. Updated FDA indications for upadacitinib (Rinvoq®).
• **Topical Agents for Skin Conditions** • **Topical Agents for Skin Conditions – Medicaid**	New policy combining criteria from multiple agents (Eucrisa®, Zoryve®, Wynzora®, Enstilar®, and Vtama®)
Upneeq	Minor update to policy criteria for documentation of superior visual field deficit criteria listing Leicester Peripheral Field Test as an example of documentation.
Vascepa	Updated wording surrounding statin use requirement to align with other policies requiring statin therapy. Intent to optimize statin therapy for ASCVD risk reduction has not changed.
Xdemvy	Updated trial and failure meds based on the latest guideline updates.
• **Xolair** • **Xolair – Medicare Part B**	Updated trial and failure duration for urticaria indication to align with the European Academy of Allergy and Clinical Immunology Guidelines. Criteria added for newly approved indication, IgE-mediated food allergy.

MEDICAL REIMBURSEMENT POLICIES	
Policy Name	**Summary of Change**
Medical Drug Reimbursement Policy: Outpatient and Inpatient	New Policy

RETIRED POLICIES	
Policy Name	**Summary of Change**
Bepreve, Zerviate	Bepreve and Zerviate will be removed from the formulary and criteria for coverage is outlined in the "Formulary and Quantity Limit Exceptions" policy.
Corticosteroid and Vitamin D Analogues	Remove prior authorization for Taclonex and moved remaining drugs (Wynzora and Enstilar) to new policy "Topical Agents for Skin Conditions"
Empaveli	Drug moved to new combined "Complement Inhibitors" policy.
Eucrisa	Drugs were moved to new combined "Topical Agents for Skin Conditions" policy.
Intranasal Medications – Commercial	Policy retired due to low utilization- formulary nasal steroids include flunisolide, fluticasone, mometasone.
Izervay	Drug combined with Syfovre policy.
Opzelura	Drugs were moved to new combined "Topical Agents for Skin Conditions" policy.
Quantity Limits of Epinephrine Auto-Injector	Retire policy due to low utilization of policy, will continue to manage utilization with epinephrine quantity limit.
• **Soliris** • **Soliris Prior Authorization and Step Therapy Policy – Medicare Part B**	Drug moved to new combined "Complement Inhibitors" policy
• **Topical Antibiotics Step Therapy Policy**	Retired prior authorization due to low risk for inappropriate utilization
• **Ultomiris** • **Ultomiris Prior Authorization and Step Therapy Policy – Medicare Part B**	Drug moved to new combined "Complement Inhibitors" policy.
• **Verkazia**	Retired prior authorization. The medication is non-formulary and criteria for coverage is outlined in the "Formulary and Quantity Limit Exceptions" policy.

• **Verquvo**	Retire policy due to low risk of inappropriate use or over utilization. The medication is non-formulary and criteria for coverage is outlined in the "Formulary and Quantity Limit Exceptions" policy.
• **Vtama, Zoryve**	Drugs were moved to new policy "Topical Agents for Skin Conditions"
• **Xhance**	Retire Xhance policy due to low utilization. Other nasal steroids are available on formulary (such as fluticasone).

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])
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	B002	B009	B019	B029	B070

B079
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B9710
B9711
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