



Line of Business (LOB) Legend:

WAH = Washington Apple Health IMC
BHSO = Behavioral Health Services Only
CS = Individual & Family (Cascade Select)
MA = Medicare Advantage
D-SNP = Medicare Special Needs Plan

Clinical Coverage Criteria (CCC)

Last Updated: 03/20/2025

CCC Name & Link	Line of Business	Last Updated	Summary of Change
MM125 Physical, Occupational and Speech Therapy	WAH CS D-SNP	3/12/2025	Added AHE, removed Medicare. Updated citations.
MM127 Arthroscopic Debridement or Lavage of Osteoarthritic Knee	WAH CS D-SNP	7/10/2024	Corrected LOBs and removed Medicare.
MM128 Orthoptic Therapy	WAH CS D-SNP	3/12/2025	Made exam criteria for initiation "or" rather than "and" so that not all findings have to be documented. Added explanation of new code 92066 for vision therapy performed by technician. Clarified source of last criteria edits in Nov 2022. Citations updated
MM129 Neuropsychological Testing	WAH CS BHSO D-SNP	6/12/2024	Redirected to LCD for Medicare, updated CCC to align with HCA billing guide, updated billing guide link, edits to reduce redundancy
MM130 Cardiac Stents	WAH CS D-SNP	7/10/2024	Corrected LOBs and removed Medicare from policy.
MM131 Transplants and Transplant Work-ups, Donor Search, Donation	WAH CS D-SNP	12/11/2024	Edited transplant work up criteria. Clarified that the Transplant team determines candidacy.
MM132 Complementary and Alternative Care	WAH CS D-SNP	1/8/2025	Removed Medicare from policy. Updated citations.
MM134 Program of Assertive Community Treatment (PACT) Program Criteria	WAH BHSO	2/12/2025	Review, minor edits
MM135 Positive Airway Pressure Devices	WAH CS D-SNP	3/12/2025	Added AASM reference for BiPAP devices for children by weight. Added AHE and removed Medicare. Updated citations.
MM136 Durable Medical Equipment	WAH CS D-SNP	12/11/2024	Removed Medicare, added AHE. Moved A55426 to references.
MM139 Skilled Nursing Facility, Comprehensive Outpatient Rehab Facility	WAH CS D-SNP	3/12/2025	SNF Leveling added. Added AHE. Removed Medicare. Updated citations.
MM141 Reconstructive Plastic Surgery	WAH CS D-SNP	1/8/2025	Removed Medicare. Updated citations.
MM143 Sterilization	WAH CS D-SNP	7/10/2024	Corrected LOBs and removed Medicare from policy and clarified D-SNP coverage.
MM144 Home Oxygen	WAH CS D-SNP	11/13/2024	Removed Medicare, updated citations
MM145 Bariatric Surgery	WAH CS D-SNP	12/11/2024	Criteria added for revision bariatric surgery
MM146 Tympanostomy Tubes	WAH CS D-SNP	10/9/2024	Removed Medicare, added AHE LOB

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MM147 Enteral Therapy Products for Enrollees with Inherited Metabolic Disorders	WAH CS D-SNP	1/8/2025	Removed Medicare. Updated citations.
MM148 Extracorporeal Membrane Oxygenation Therapy	WAH CS D-SNP	10/9/2024	Removed Medicare, added AHE LOB
MM149 Spinal Injections and Facet Neurotomy	WAH CS D-SNP	1/8/2025	Removed Medicare. Updated citations.
MM151 Nonpharmacologic Treatments for Treatment-Resistant Depression	WAH CS BHSO D-SNP	11/13/2024	Added definition of TRD, minor grammar and formatting edits
MM152 Intensity Modulated Radiation Therapy IMRT	WAH CS D-SNP	2/12/2025	Removed Medicare. Added AHE. Updated citations.
MM153 Proton Beam Therapy	WAH CS D-SNP	7/10/2024	Corrected LOBs and removed Medicare from policy
MM154 Applied Behavioral Analysis	WAH BHSO CS	8/5/2024	Updated recertification section to align with WAC 182-531A-1100 allowing request for updated COE evaluation. Added WAC link. Updated WAC reference for COE definitions, removed statement that in-school ABA is not medically necessary, per HCA guidance
MM155 Wraparound with Intensive Services Program (WISe) for AH-IMC and BHSO	WAH BHSO	6/12/2024	Updated WAC links, reviewed content. No edits.
MM158 Prosthetics, Orthotics, and Therapeutic Diabetic Shoes	WAH CS D-SNP	11/13/2024	Added criteria from MM162. Corrected last approval was by the UM Criteria Subcommittee.
MM159 Medically Intensive Children's Program (MICP)	WAH	1/8/2025	Corrected codes for private duty nursing. Updated citations.
MM162 Medical Appropriateness for Service or Medication	WAH CS BHSO MA D-SNP	5/8/2024	Clarified that pricing is needed to determine if the service requires PA.
MM163 Hospice Care, Pediatric Concurrent Care, and Pediatric Palliative Care	WAH CS D-SNP	11/13/2024	Removed Medicare. Minor edits and updates to citations.
MM164 Clinical Trials for Treatments and Devices	WAH CS D-SNP	1/8/2025	Medicare removed and citations updated
MM165 Genetic Testing	WAH CS D-SNP	1/8/2025	Added reference to DEX Diagnostics Exchange. Added single gene or targeted panel to general criteria. Moved genetic testing for cancers from the general criteria to specific criteria for cancer.
MM166 Gender Affirming Care	WAH CS D-SNP	3/12/2025	Added details of covered services for Cascade Select members based on SME feedback.
MM167 Speech Generating Devices (Augmentative Communication Devices)	WAH CS D-SNP	3/12/2025	Added AHE, Removed Medicare, Updated citations, Clarified that the records must show a medical condition resulting in a severe permanent speech disorder.
MM168 Hearing Assist Devices	WAH CS D-SNP	5/8/2024	Corrected criteria for BAHA for EPSDT members to include hearing loss of at least 20 dB. Corrected citations.
MM169 Bathroom and Toilet DME and Supplies	WAH CS D-SNP	2/12/2025	Removed Medicare, added AHE, updated citations
MM170 Drug Testing in Substance Use Disorder Treatment and Pain Management	WAH CS BHSO D-SNP	3/12/2025	Added AHE. Removed Medicare. Updated citations and links to LCD for Washington, effective on 4/17/25. Added health equity. Removed LCD references for Individual & Family. Added redirection to LCD for Medicare

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MM171 Inpatient Rehabilitation	WAH CS D-SNP	10/9/2024	Removed Medicare, added AHE LOB
MM172 Home Health Skilled Services	WAH CS D-SNP	3/12/2025	Removal of limitation for HH SN services. Added AHE, Removed Medicare. Updated citations.
MM176 Psychological Testing	WAH CS BHSO D-SNP	6/12/2024	Redirection to LCD for Medicare members, updated clinical coverage criteria for other LOBs to align with 2024 HCA billing guide criteria, updated link to HCA billing guide
MM177 Eating Disorders, Inpatient Behavioral Health Level of Care	WAH CS BHSO D-SNP	6/12/2024	Reviewed, no changes
MM178 Eating Disorders, Partial Hospital Behavioral Health Level of Care	WAH CS BHSO D-SNP	6/12/2024	Reviewed, no changes
MM179 Eating Disorders, Residential Behavioral Health Level of Care	WAH CS BHSO D-SNP	6/12/2024	Removed "and anorexia nervosa" from title . No other changes
MM180 Electroconvulsive Therapy (ECT)	WAH CS BHSO D-SNP	6/12/2024	Updated to specify treatment resistance must be from medication trials during current depressive episode; Minor grammatical edits
MM181 Repetitive Transcranial Magnetic Stimulation (rTMS)	WAH CS BHSO D-SNP	6/12/2024	Updated links for LCD and HCA Mental Health Billing Guide. Redirect to LCD for Medicare members added. Updated criteria to require medication trials during current episode. Moved relative contraindications to "Special Considerations". Modified repeat treatment criteria to align with HCA MH billing guide and LCD
MM182 Peripheral Nerve Blocks, Diagnostic Injections, Ablations and Electrostimulation	WAH CS D-SNP	2/12/2025	Added AHE, removed Medicare. Corrected Criteria For Infusion of Local Anesthetics for Nerve Block based on L35457. Updated citations.
MM183 Cervical Or Lumbar Spinal Fusion For Patients With Degenerative Disc Disease	WAH CS D-SNP	1/8/2025	Removed Medicare. Updated citations.
MM184 Pharmacogenetic Testing	WAH CS BHSO D-SNP	10/9/2024	Removed Medicare, added AHE LOB
MM185 Sacroiliac Joint Fusion	WAH CS D-SNP	11/13/2024	Removed Medicare. Updated citations.
MM186 Hip Surgery for Femoroacetabular Impingement (FAI) Syndrome	WAH CS D-SNP	11/13/2024	Removed Medicare. Updated citations.
MM188 Out of Area Medical or Behavioral Health Services for AH-IMC Members	WAH BHSO CS	2/12/2025	Clarification of definition of Out of Area
MM189 Out of Network Policy for Cascade Select	CS	11/13/2024	Reviewed, no edits.
MM190 Knee and Hip Arthroplasty for Osteoarthritis	WAH CS D-SNP	1/8/2025	Removed Medicare. Updated citations.
MM192 Spinal Cord Stimulation for Treatment of Chronic Pain	WAH CS D-SNP	11/25/2024	Added criteria to align with new HTCC criteria: 20240517A – Spinal cord stimulation. Removed Medicare. Updated Citations.
MM193 New Journeys Coverage Criteria for AH-IMC and BHSO	WAH BHSO	2/12/2025	Updated maximum coverage length to 5 years to align with current SERI guide; Updated coverage criteria to match new inclusion criteria for mood disorders with psychosis
MM194 Intensive Behavioral Health Treatment Facility	WAH BHSO	11/13/2024	Reviewed, no changes made
MM195 Wheelchair	WAH CS D-SNP	9/11/2024	Removed Medicare
MM196 Intensive Behavioral Supportive Supervision (IBSS)	WAH BHSO	11/13/2024	Added cost-effectiveness requirement, minor formatting edits
MM197 Mental Health Partial Hospitalization Programs (PHP)	WAH CS BHSO D-SNP	11/13/2024	Updated service lines, added reference to LCD for Medicare members

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MM198 Mental Health Intensive Outpatient Programs (IOP)	WAH CS BHSO D-SNP	2/12/2025	Added continued stay criteria, requirement for Limitation Extension request
MM199 Out-of-Network Medical or Behavioral Health Services for Medicare Member	MA	3/12/2025	Added definitions. Ensured alignment with OP216, OP610, and UM436.
MM200 Community Behavior Health Support (CBHS)	WAH MA	7/10/2024	New policy
MM201 Shoulder Arthroscopy and Shoulder Arthroplasty	MA D-SNP	11/13/2024	New policy
MM202 Knee Arthroscopy and Arthroplasty	MA D-SNP	11/13/2024	New policy
MM203 Hip Arthroscopy and Arthroplasty	MA D-SNP	11/13/2024	New policy
MM204 Lumbar Surgeries	MA D-SNP	11/13/2024	New policy
MM205 Coronary Artery Calcium Scoring	MA D-SNP	11/13/2024	New policy
PM101 Hydroxyprogesterone caproate Makena injection for intramuscular use	WAH CS MA D-SNP	9/11/2024	Annual review. No changes
PM103 Ipilimumab (Yervoy)	WAH CS MA D-SNP	11/13/2024	Annual review. Update the wording for the Colon or Rectal Cancer Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) criteria to require the patient is receiving neoadjuvant chemotherapy or has unresectable or metastatic disease.
PM104 Pemetrexed (Alimta® and Pemfexy®)	WAH CS MA	3/12/2025	Annual review. Expanded on treatment criteria for NSCLC tumors with "EGFR Exon 19 Deletion or Exon 21 L858R" and "EGFR Exon 20 Insertion Mutation". Added methotrexate-intolerant/unsuitable as a part of criteria for approval in PCNSL. Added criteria for NSCLC tumors with NTRK Gene-fusion mutations. Added NCCN guideline recommendation for vaginal cancer in Background section. Added additional brands, Pemrydi RTU and Axtle, where applicable (PM description, Cascade/Medicare coverages, Background). Changed "oropharyngeal cancer" to "non-nasopharyngeal cancer under Head and Neck Cancer section.
PM105 Brentuximab vedotin (Adcetris)	WAH CS MA D-SNP	11/13/2024	Annual review. No criteria change
PM108 Pertuzumab (Perjeta)	WAH CS MA D-SNP	9/11/2024	Annual review. No criteria change
PM109 Palivizumab (Synagis)	WAH CS MA D-SNP	2/12/2025	Annual review. No criteria changes
PM110 Nanoparticle albumin bound paclitaxel (Abraxane)	WAH CS MA D-SNP	6/12/2024	Annual review. For Kaposi Sarcoma, added criteria to requiring the patient to be intolerant to paclitaxel. For Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, removed requirement to try one other systemic chemotherapy. For Small Bowel Adenocarcinoma, removed requirement to require prior oxaliplatin exposure in the adjuvant setting or contraindication.
PM112 Ramucirumab (Cyramza)	WAH CS MA D-SNP	11/13/2024	Annual revision. Added criteria for thymic carcinomas.
PM114 Epoprostenol (Flolan, Veletri), generics	WAH CS MA D-SNP	9/11/2024	Annual Review. No changes
PM115 Cetuximab (Erbixub)	WAH CS MA D-SNP	12/11/2024	Annual review. For Colon or Rectal Cancer with KRAS G12C mutation-positive disease, included that Erbitux can be used for subsequent line treatment in combination with Lumakras (sotorasib tablets) or Krazati (adagrasib tablets). Added indication of Appendiceal Adenocarcinoma.
PM116 Ado-trastuzumab emtansine (Kadcyla)	WAH CS MA D-SNP	3/12/2025	Annual Review. No changes.

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PM117 Pembrolizumab (Keytruda)	WAH CS MA D-SNP	6/12/2024	Annual revision. <i>Cervical cancer</i> : Added criteria option where Keytruda may be used in combination with chemoradiation therapy in patients with FIGO 2014 Stage III to IVA cervical cancer. For patients who have tumor expression for PD-L1, Keytruda may be approved if Keytruda is used in combination with chemotherapy or as a single agent if the patient has tried previous chemotherapy. <i>Endometrial cancer</i> : Clarified criteria where patient that do not have MSI-H or dMMR must use Keytruda in combination with carboplatin and paclitaxel for all endometrial carcinoma-related indications except for carcinosarcoma. Added criteria that Keytruda may be covered in patients with pMMR if Keytruda is used in combination with lenvatinib. <i>Esophageal and esophagogastric junction cancer</i> : Added criteria that the patient must have locally advanced or metastatic disease. Removed criteria requiring that the patient's tumor is s human epidermal growth factor 2 (HER2)-positive disease and is using the medication in combination with a trastuzumab product, fluoropyrimidine (e.g., fluorouracil [5-FU], capecitabine), platinum-containing chemotherapy. Removed criteria requiring that the patient's tumor expression for programmed death-ligand 1 (PD-L1) as determined by an approved test has a combined positive score (CPS) ≥ 1 . Added criteria where the patient must meet one of the following: i) the medication is used in combination with platinum- and fluoropyrimidine-based chemotherapy OR ii) The medication is used as a single agent after one or more prior lines of systemic therapy for patients with tumors that express PD-L1 (CPS of ≥ 10). <i>Gastric cancer</i> : Updated criteria where patients with HER2 positive disease must require that the tumor expresses PD-L1 (CPS ≥ 1) and
PM118 Alemtuzumab (Lemtrada)	WAH CS MA D-SNP	6/12/2024	Annual review. Medicaid criteria is updated to only require a history of failure, contraindication, or intolerance to two preferred products indicated for the treatment of multiple sclerosis (preferred products include: Avonex [interferon beta-1a injection], Betaseron [interferon beta-1b injection], Copaxone [glatiramer acetate injection, brand], generic dimethyl fumarate, and Kesimpta [ofatumumab injection]). Patients with a previous approval from Community Health Plan of Washington may be approved for 1 year. Cascade Select criteria is updated to follow Medicare criteria.
PM119 Nivolumab (Opdivo)	WAH CS MA D-SNP	11/13/2024	Annual Review. Updated criteria for the following indications: classic Hodgkin lymphoma, Colon or Rectal Cancer, Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR), Gastric Cancer, Anal Carcinoma, Head and Neck Squamous Cell Carcinoma, Malignant Pleural Mesothelioma, Urothelial Carcinoma, Anal Carcinoma, Neuroendocrine Tumors, and Soft Tissue Sarcoma. Esophageal Squamous Cell Carcinoma was changed to Esophageal Carcinoma. Pancreatic Adenocarcinoma was changed to Pancreatic Carcinoma. Criteria was added for Vaginal Cancer and Thyroid Carcinoma – Anaplastic.
PM122 Trepstinil (Remodulin)	WAH CS	12/11/2024	Early update. Updated step therapy criteria for brand Remodulin
PM126 Integrin Receptor Antagonists	WAH CS MA D-SNP	3/12/2025	Early update. Title of policy was changed to Integrin Receptor Antagonist Clinical Coverage to criteria because Entyvio was added to the policy. For Medicaid, criteria was updated to account for Medical Policy No. 66.27.00-AJ-5, which includes Entyvio. For Cascade Select and Medicare, criteria for Entyvio was added.
PM127 Panitumumab (Vectibix) solution for intravenous infusion	WAH CS MA D-SNP	2/12/2025	Annual review. Criteria was updated to require that the patient has meets one of the following: i) Patient's tumor or metastases are wild-type RAS (KRAS wild-type and/or NRAS wild-type) and wild-type BRAF [that is, the tumor or metastases are KRAS, NRAS, and BRAF mutation negative]; OR ii) Patient's tumor or metastases are KRAS G12C mutation positive and the medication is used in combination with either sotorasib or adagrasib; OR iii) Patient's tumor or metastases are BRAF V600E mutation-positive and the patient meets the following: a) Patient has previously received a chemotherapy regimen for colon or rectal cancer AND b) The medication is prescribed in combination with encorafenib.
PM129 Rituximab products	WAH CS MA D-SNP	12/11/2024	Early update. Moved Riabni from non-preferred to one of the preferred products.
PM132 Trastuzumab Products	WAH CS MA D-SNP	2/12/2025	Early update. Added Hecessi (trastuzumab-strf), a new biosimilar, to the policy as a non-preferred product.

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PM133 Ziv-aflibercept (Zaltrap)	WAH CS MA D-SNP	2/12/2025	Annual review. No criteria changes.
PM134 Denosumab (Prolia)	WAH CS MA D-SNP	12/11/2024	Annual Update. In Medicare criteria for treatment of postmenopausal osteoporosis or osteoporosis in men, osteoporotic fracture or fragility fracture was made into its own sub-criteria independent of other sub-criteria.
PM135 Denosumab (Xgeva)	WAH CS MA D-SNP	9/11/2024	Annual review. Local Coverage Determination (LCD) Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications (L33270) is no longer applicable for Medicare LOB. Removed description of LCD under the Medicare section.
PM136 Epoetin Products	WAH CS MA D-SNP	9/11/2024	Early update. Updated criteria section for non-preferred products. In addition to requiring that the member try one of the preferred product (Aranesp, Procrit, Retacrit), there must be documentation on that the patient cannot continue to use the Preferred medication due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Added label to specify what section is the Medicaid criteria.
PM138 Ibandronate (Boniva)	WAH CS MA D-SNP	6/12/2024	Annual review. No revisions.
PM139 Immune globulin subcutaneous	WAH CS MA D-SNP	9/11/2024	Early update. Removed drug specific criteria for HyQvia. HyQvia will use the same criteria as the other immune globulin products. HyQvia dosing for Primary Immunodeficiencies: The dose and interval between doses has been adjusted based on clinical response as determined by the prescribing physician was updated to prescriber. HyQvia dosing for Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) or Polyradiculoneuropathy was added
PM140 Darbepoetin alfa (Aranesp)	WAH CS MA D-SNP	9/11/2024	Early update. Removed "and Cascade Select" from the Medicaid Criteria section.
PM141 Omalizumab (Xolair) injection for subcutaneous use	WAH CS MA D-SNP	3/12/2025	Annual Review. For Medicaid, updated 3rd indication to be labeled as "Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)". For Medicare, updated the indication "Nasal Polyps" to be "Chronic Rhinosinusitis with Nasal Polyps". For Medicare, added Immunoglobulin (Ig)E-Medicated Food Allergy as a new indication. "Peanut and Other Food Allergies" was removed as a Condition Not Recommended for Approval.
PM142 Ocrelizuman (Ocrevus) injection for intravenous use	WAH CS MA D-SNP	12/22/2024	Early update. Added Ocrevus Zunovo to the policy.
PM144 Hyaluronic acid derivatives (such as Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz/Supartz FX, Synjoynnt, Synvisc, Synvisc-One, TriVisc, Visco-3)	WAH CS MA D-SNP	6/12/2024	Annual review. Hyaluronic acid derivatives are non-covered for Medicaid starting 7/1/24 according to the Washington Health Care Authority.
PM145 Immune Globulin Intravenous (IVIG) (Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard S/D < 1 mcg/dL in 5% solution, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, Privigen Liquid)	WAH CS	5/8/2024	Early update. Aylglo was added to the drug policy. For immune thrombocytopenia, the duration of approval for initial therapy for adults and pediatric patients was changed from 1 year to 3 months. Continuation criterion was also updated from "Patient has responded to therapy" to patient is responding to therapy OR the patient has previously responded to therapy.
PM147 Cytokine, TNF inhibitors, & CAM Antagonists (including abatacept (ORENCIA), anakinra (KINERET), canakinumab (ILARIS), certolizumab pegol (CIMZIA), golimumab (SIMPONI ARIA), infliximab (INFLECTRA, RENFLEXIS, REMICADE), secukinumab (COSENTYX), tocilizumab (ACTEMRA), ustekinumab (STELARA), vedolizumab (ENTYVIO))	WAH CS	2/12/2025	Early update. Added Wezlana (ustekinumab-auub) to the Cascade Select/Medicare criteria. Added age requirements to Cascade Select/Medicare criteria.

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PM149 Antiasthmatic Monoclonal Antibodies-IL-5 Antagonists	WAH CS MA D-SNP	12/11/2024	Early update. For the Medicare LOB (Eosinophilic granulomatosis with polyangiitis): Criteria requiring the patient to have tried a minimum of 4 weeks of corticosteroid therapy were clarified to require the patient be currently receiving a systemic corticosteroid and have been on therapy for a minimum of 4 weeks. For Medicare, added Tezspire to the list of preferred drugs. For non-preferred drugs for Medicare, criteria was updated to require that the patient has tried two of Fasenna, Nucala, and/or Tezspire.
PM150 Complement C5 Inhibitor	CS MA D-SNP	11/23/2024	Annual policy review. Added PiaSky as a part of the of policy with criteria for paroxysmal nocturnal hemoglobinuria. Added neuromyelitis optica spectrum disorder as a covered condition for Ultomiris. Criteria for neuromyelitis optica spectrum disorder was updated to remove criterion that required prior use of two therapies and criterion that patient has had a history of at least one relapse in the last 12 months or two relapses in the last 2 years. For neuromyelitis optica spectrum disorder, "Improvement in Functional Assessment of Chronic Illness Therapy (FACIT)-Fatigue score" was added to the Note of examples of benefit. Add several conditions not recommended for approval.
PM151 Buprenorphine for subcutaneous use (Sublocade)	WAH CS MA D-SNP	9/11/2024	Annual review. No changes
PM152 Enzymes for Gaucher Disease	CS MA D-SNP	11/13/2024	Annual review. Specified criteria to be for Gaucher disease – Type 1. Clarified age requirements for Cerezyme and Eleyso for Gaucher disease – Type 1. For diagnosis established by genetic testing, genetic testing demonstrating a mutation in the glucocerebrosidase (GBA) gene was further specified to state a genetic test documenting biallelic pathogenic variants in the GBA gene. Added criteria for Gaucher disease – Type 3.
PM153 Romiplostim (Nplate)	WAH CS MA D-SNP	12/11/2024	Annual Review. No criteria changes.
PM154 Corticotropin (H.P. Acthar Gel)	WAH CS MA D-SNP	11/13/2024	Annual review. For Cascade Select/Medicare criteria, criterion was added to require that corticotropin is administered as an intramuscular injection.
PM155 Filgrastim Products	WAH CS MA D-SNP	2/12/2025	Annual review. For Medicare: Added Nypozi to the policy as a non-preferred product. For "Bone Marrow Transplant in a Patient with Cancer Who Received Chemotherapy", updated criteria to requires that the medication is prescribed by or in consultation with a hematologist, an oncologist, or a physician who specializes in transplantation. Granix was added to the list of products indicated for "Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome)".
PM157 Afamelanotide implant (Scenesse)	CS MA D-SNP	11/13/2024	Annual Review. No criteria change.
PM158 Capacizumab injection (Cablivi)	WAH CS MA D-SNP	12/11/2024	Annual review. No criteria changes.
PM159 Esketamine nasal spray (Spravato)	WAH CS MA D-SNP	12/11/2024	Annual review. No criteria changes.
PM160 Teprotumumab injection (Tepezza)	CS MA D-SNP	2/12/2025	Annual review. No criteria changes.
PM161 Inebilizumab injection (Uplizna)	CS MA D-SNP	11/13/2024	Annual Review. No criteria changes.
PM162 Crizanlizumab (Adakveo)	CS MA D-SNP	1/8/2025	Annual review. No criteria changes.
PM163 Burosumab (Crysvita)	CS MA D-SNP	1/8/2025	Annual Review. No criteria changes.
PM164 Cerliponase alfa (Brineura)	CS MA D-SNP	1/8/2025	Annual Review. Guideline recommendations added in background. No additional changes made.

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PM165 Duchenne Muscular Dystrophy gene therapy (Exondys 51, Vyondys, Viltepsol)	CS MA D-SNP	11/13/2024	Annual Review. No criteria changes
PM166 Edavarone (Radicava)	CS MA D-SNP	1/8/2025	Annual review. No criteria changes.
PM167 Elapegedemase (Revcovi)	CS MA D-SNP	1/8/2025	Annual review. No criteria changes.
PM168 Emopalumab (Gamifant)	CS MA D-SNP	1/8/2025	Annual review. No criteria changes
PM169 Givosiran (Givlaari)	CS MA D-SNP	11/13/2024	Annual review. No criteria changes.
PM170 Nusinersen (Spinraza)	CS MA D-SNP	11/13/2024	Annual review. In criteria that the patient has not received Zolgensma in the past (with verification in claims history required), the Note was revised to account for situations in which a claims history is not available.
PM171 Onasemnogene abeparvovec (Zolgensma)	CS MA D-SNP	11/13/2024	Annual review. No criteria changes.
PM172 Pegvaliase (Palynziq)	CS MA D-SNP	1/8/2025	Annual review. No criteria changes.
PM173 Voretigene neparvovec (Luxterna)	CS MA D-SNP	1/8/2025	Annual review. No criteria updates.
PM175 Calcitonin Gene-Related Peptide Inhibitors (i.e.: Eptinezumab (Vyepti)) Clinical Coverage Criteria	WAH CS MA D-SNP	9/11/2024	Early update. The criteria requiring a patient to have tried at least two standard prophylactic (preventive) pharmacologic therapies, each from a different pharmacologic class, and requiring that a patient have had inadequate efficacy or adverse event(s) severe enough to warrant discontinuation of those therapies have been removed. Added "Concurrent use with another calcitonin gene-related peptide (CGRP) inhibitor being prescribed for migraine headache prevention" to the list of conditions not recommended for approval.
PM176 Enzyme replacement therapy	WAH CS MA D-SNP	2/12/2025	Early update. For Fabrazyme criteria, removed age requirement criteria and the term "mutation" was rephrased to "pathogenic variant."
PM177 Gonadotropin-Releasing Hormone Agonist Therapy for Gender Dysphoria	WAH CS	9/11/2024	Annual review. Removed Cascade Select and Medicare sections from the Indications/Criteria table.
PM180 Cabotegravir/rilpivirine (Cabenuva)	CS MA	7/10/2024	Annual review. Added criteria to require patients be at least 35 kg (was previously not added as of last update).
PM181 Inclisiran (Leqvio)	WAH CS MA D-SNP	9/11/2024	Early update. The requirement that the medication is prescribed by, or in consultation with a cardiologist; an endocrinologist; or a physician who focuses in the treatment of cardiovascular risk management and/or lipid disorders was removed. A patient with diabetes now qualifies for primary hyperlipidemia (if requirements are met). For Heterozygous Familial Hypercholesterolemia, updated mutation criteria to state the following: Patient has phenotypic confirmation of heterozygous familial hypercholesterolemia. Listed examples of phenotypes. Name of indication was changed from "Atherosclerotic Cardiovascular Disease" to Established Cardiovascular Disease".
PM182 Anifrolumab (Saphnelo) and Belimumab (Benlysta)	WAH CS MA D-SNP	2/12/2025	Annual review. For Benlysta for Cascade Select/Medicare criteria, updated criteria for lupus nephritis. Required that diagnosis of lupus nephritis has been confirmed on biopsy. For initial therapy in patients currently receiving Benlysta, required that the medication is being used concurrently with an immunosuppressive regimen. Examples of immunosuppressive regimen include azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate mofetil, and/or a systemic corticosteroid.
PM183 Bevacizumab	WAH CS MA D-SNP	12/11/2024	Early update. Alymsys was moved from a Non-Preferred to a Preferred Product. Requirement that the patient tried one of Mvasi or Zirabev was revised to require patient to try TWO of the following: Alymsys, Mvasi, or Zirabev. Documentation requirement was added for step through TWO preferred products.

CCC Name & Link	Line of Business	Last Updated	Summary of Change
PM184 Long-Acting Granulocyte Colony Stimulatin (G-CSF) Products (Pegfilgrastim and Eflapegrastim-xnst)	WAH CS MA D-SNP	12/11/2024	Early update. Stimufend was moved to the preferred products. Nyvepria was moved to the non-preferred products.
PM185 Sutimlimab-jome (Enjaymo)	CS MA	7/10/2024	Annual review. No criteria updates.
PM186 Ublituximab (Briumvi®)	WAH CS MA D-SNP	1/8/2025	Annual review. Medicaid criteria has been updated to be the same as Cascade Select and Medicare criteria.
PM187 Phesgo	WAH CS MA D-SNP	9/11/2024	Annual Review. No criteria updates
PM188 Betibeglogene autotemcel (Zynteglo™)	CS MA	12/11/2024	Early update. Age criteria was changed to only require patients be ≥4 years of age.
PM189 Lecanemab (Leqembi®)	CS	10/9/2024	Annual Review. Added background information. No criteria changes.
PM190 Cantharidin (Ycanth)	WAH-IMC CS	3/12/2025	Annual Review. No criteria changes.
PM191 IncobotulinumtoxinA (Xeomin)	WAH CS MA D-SNP	12/11/2024	New policy
PM192 AbobotulinumtoxinA (Dysport)	WAH CS MA D-SNP	2/12/2025	Early update. For Medicare, Oromandibular Dystonia was added to the policy.
PM193 Atidarsagene Autotemcel (Lenmeldy™)	CS MA D-SNP	12/11/2024	New policy
PM194 DaxibotulinumtoxinA (Daxxify)	WAH CS MA D-SNP	2/12/2025	Early update. The maximum dosing limitation was lowered from 300 to 250 units for Medicare.
PM195 RimabotulinumtoxinB (Mybloc)	WAH CS MA D-SNP	12/11/2024	New policy
PM567 Hereditary Angioedema Agents	CS MA	3/12/2025	Annual Review. No revisions
PM568 Transthyretin Amyloidosis Agents	CS MA	12/11/2024	Early update. For Amvuttra: For diagnosis confirmed by genetic testing, rephrased the term "mutation" to "pathogenic variant"
PM569 Triamcinolone ER (Zilretta)	WAH CS MA D-SNP	3/12/2025	Annual review. No criteria changes.

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PM570 Botulinum Toxins	WAH CS	2/12/2025	Early update (for Medicare). Achalasia: The following Note was added: Achalasia is also referred to as esophageal achalasia or achalasia cardia. Anal Fissure, Chronic: The diagnosis was updated from "Anal Fissure" to as listed. The dosing limitation was lowered from 400 units to 100 units. Chronic Facial Pain/Pain Associated with Temporomandibular Dysfunction: This Other Use with Supportive Evidence was removed from the Policy. Chronic Low Back Pain: This Other Use with Supportive Evidence was removed from the Policy. Dystonia, Focal Upper Limb: This Other Use with Supportive Evidence was added to the Policy. A new dosing limitation was added. Dystonia, other than Cervical: This Other Use with Supportive Evidence was removed from the Policy. Essential Tremor: The Note providing pharmaceutical examples of medications used to treat tremors was updated to add both atenolol and sotalol, and benzodiazepines were replaced with alprazolam. Hyperhidrosis, Primary Axillary: Requirements were added that hyperhidrosis is significantly interfering with the ability to perform age-appropriate activities of daily living and that the prescriber has excluded secondary causes of hyperhidrosis. The requirement for a trial of at least one topical agent was updated to add that the trial was for a prescription agent for at least 4 weeks and the patient experienced inadequate efficacy or significant intolerance. The Note providing examples of prescription topical agents for the treatment of axillary hyperhidrosis was updated to include Xerac AC (aluminum chloride 6.25% topical solution), Drysol (aluminum chloride 20% topical solution), and Sofdra (glycopyrronium 12.45% topical gel). Hyperhidrosis, Primary Palmar/Plantar/Facial: This Other Use with
PM572 Lumasiran injection (Oxlumo)	CS MA	12/11/2024	Annual review. No criteria changes
PM573 Bimatoprost (Durysta)	CS MA	3/12/2025	Annual Review. No criteria updates
PM574 Intravitreal Corticosteroids	WAH CS MA D-SNP	3/12/2025	Annual Review. No criteria changes.
PM575 Tezepelumab (Tezspire)	WAH CS MA D-SNP	3/12/2025	Annual Review. No criteria changes.
PM576 Efgartigimod Alfa (Vyvgart)	CS MA	12/11/2024	Early update. Added criteria for chronic inflammatory demyelinating polyneuropathy for Vyvgart Hytrulo only. Removed Ultomiris subcutaneous injection from the Note of examples of complement inhibitors
PM577 Alpha-Proteinase Inhibitor (Human)	WAH CS MA D-SNP	9/11/2024	Annual review. No criteria updates.
PM578 Cabotegravir (Apretude)	CS	12/11/2024	Annual review. Updated policy to note that Apretude is covered and does not require prior authorization for Medicaid
PM579 Spesolimab-sbzo (Spevigo)	CS MA	3/12/2025	Annual Review. Updated dosing regimen to include the dosing regimen for patients with an active flare and the dosing regimen for patients without an active flare. Reauthorization criteria was updated to require that the patient experienced a beneficial clinical response (i.e., improvement from baseline). Initial authorization will be approved for up to 6 months. Reauthorization will be approved for up to one year.
PM580 Olipudase alfa (Xenpozyme)	CS MA	3/12/2025	Annual Review. No criteria updates.
PM581 Hemophilia Products	CS MA	12/11/2024	Early update. Added Beqvez to the policy with criteria.
PM582 Panhematin (Hemin)	WAH CS MA D-SNP	6/12/2024	Annual review. No criteria updates.
PM583 Sandostatin LAR Depot (Octreotide Intramuscular Injection) and Lanreotide	WAH CS MA D-SNP	6/12/2024	Annual review. No criteria updates.

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PM584 Elranatamab-bcmm (Elrexio)	WAH CS MA D-SNP	11/13/2024	Annual review. No criteria changes.
PM585 Gonadotropin-Releasing Hormone Agonists – Injectable Long-Acting Products	WAH CS MA D-SNP	2/12/2025	Early update. Added Camcevi, Eligard, and Triptodur to the policy for Prostate Cancer and Head and Neck Cancer – Salivary Gland Tumors.
PM586 Faricimab-svoa (Vabysmo)	WAH CS MA D-SNP	10/9/2024	Annual Review. Macular Edema Following Retinal Vein Occlusion: This condition and criteria for approval was added to the policy.
PM587 Rozanolixizumab-noli (Rystiggo)	CS MA	12/11/2024	Annual review. For Conditions Not Recommended for Approval, Concomitant Use with Another Neonatal Fc Receptor Blocker, a Complement Inhibitor, or a Rituximab Product: Removed Ultomiris subcutaneous injection from the Note of examples of complement inhibitors.
PM588 Ranibizumab (Susvimo)	WAH CS MA D-SNP	11/13/2024	Annual Review. Added the following criteria to review for Susvimo: The patient has tried two intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor. Documentation of rationale showing why the patient requires Susvimo given the safety concerns regarding endophthalmitis. The medication will be prescribed by or in consultation with an ophthalmologist.
PM592 Beremagene Geperpavec (Vyjuvek)	CS MA	11/13/2024	Annual review. No criteria changes
PM593 Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty	CS MA	12/11/2024	Early update. Added Supprelin LA to the policy. Triptodur, Lupron Depot-Ped, and Supprelin LA were listed as preferred products. Fensolvi was listed as a non-preferred product
PM594 Syfovre (pegcetacoplan [intravitreal])	WAH CS MA D-SNP	12/11/2024	Annual review. No criteria changes
PM595 Motixafortide (Aphexda)	WAH CS MA D-SNP	7/10/2024	New policy
PM596 Pozelimab-bbfg (Veopoz)	WAH CS MA D-SNP	7/10/2024	New policy
PM600 IL-6 Inhibitor	WAH CS MA SNP	3/12/2025	New policy
PM601 IL-12/IL-23 Inhibitor	WAH CS MA SNP	3/12/2025	New policy
PM602 IL-17 Inhibitor	WAH CS MA SNP	3/12/2025	New policy
PM603 T-Lymphocyte Inhibitor	WAH CS MA SNP	3/12/2025	New policy
PM604 TNF Inhibitor	WAH CS MA SNP	3/12/2025	New policy