COMMUNITY HEALTH PLAN of Washington™
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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: 11/27/2024

CCC Name & Link	Line of Business	Last Updated	Summary of Change
MM125 Physical, Occupational and Speech Therapy	WAH CS D-SNP	4/10/2024	Added criteria from CMS memorandum to remind Medicare Advantage Organizations of certain skilled therapy coverage and training policies related to the Jimmo v. Sebelis Settlement Agreement. Prior level of function included with required documentation.
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	4/10/2024	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	11/13/2024	Removed Medicare. Edited criteria for Stem Cell and Multi-visceral organ transplantation. Corrected approval body to UM Criteria Subcommittee.
MM132 Complementary and Alternative Care	WAH CS D-SNP	2/14/2024	Clarified Medicare first 12 chiropractic visits in a year do not require PA and the criteria for continued chiropractic care.
MM134 Program of Assertive Community Treatment (PACT) Program Criteria	WAH BHSO	3/13/2024	Review, no changes
MM135 Positive Airway Pressure Devices	WAH CS D-SNP	4/10/2024	Clarified CMS criteria for NIV. Updated citations and links.
MM136 Durable Medical Equipment	WAH CS D-SNP	3/13/2024	Added A55426. For replacement of DME for Medicare members.
MM139 Skilled Nursing Facility, Comprehensive Outpatient Rehab Facility	WAH CS D-SNP	4/10/2024	Added criteria from CMS memorandum to remind Medicare Advantage Organizations of certain skilled therapy coverage and training policies related to the Jimmo v. Sebelis Settlement Agreement. Prior level of function included with required documentation.
MM141 Reconstructive Plastic Surgery	WAH CS D-SNP	2/14/2024	Minor edits. Corrected links. 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	9/11/2024	Removed references to Medicare and CMS criteria.

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MM146 Tympanostomy Tubes	WAH CS D-SNP	10/9/2024	Removed Medicare, added AHE LOB
MM147 Enteral Therapy Products for Enrollees with Inherited Metabolic Disorders	WAH CS D-SNP	2/14/2024	Updated links, minor edits. 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	2/14/2024	Corrected LCD for Sacroiliac joint injection. 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	3/13/2024	Changed Medicare criteria to MCG. 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 BHSO CS	2/14/2024	Reviewed policy and 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 BHSO D-SNP	2/14/2024	Added WAC Hierarchy of Evidence. Updated citations.
MM165 Genetic Testing	WAH CS D-SNP	9/11/2024	Added minor procedures to criteria for Gender Affirming Surgery or Procedure. Removed MA, added AHE LOB
MM166 Gender Affirming Care	WAH CS D-SNP	11/13/2024	Added minor procedures to criteria for Gender Affirming Surgery or Procedure. Removed MA, added AHE LOB. Reviewed and edited changes by Care Management Department LGBTQIA+ SME. Clarified responsibility for gender affirming services for AH members.
MM167 Speech Generating Devices (Augmentative Communication Devices)	WAH CS D-SNP	5/8/2024	Clarified Medicare criteria. Removed reference to CHNW. Corrected citations.
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	3/13/2024	Clarified that the home assessment can be performed by the DME supplier. Minor edit. Updated citations

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MM170 Drug Testing in Substance Use Disorder Treatment and Pain Management	WAH CS BHSO D-SNP	4/10/2024	Clarified CMS criteria are the LCD. Corrected links. Added LCA
MM171 Inpatient Rehabilitation	WAH CS D-SNP	10/9/2024	Removed Medicare, added AHE LOB
MM172 Home Health Skilled Services	WAH CS D-SNP	5/8/2024	Corrected explanation of initial 6 HH services. Clarified that continuation criteria apply to all lines of business.
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	3/13/2024	Removed summary of LCD/LCA for Medicare members. Clarified the CMS criteria for Medicare. Updated citations.
MM183 Cervical Or Lumbar Spinal Fusion For Patients With Degenerative Disc Disease	WAH CS D-SNP	2/14/2024	Corrected Medicare criteria to A53975. Corrected operative status criteria. 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	2/14/2024	Reviewed policy, minor edits, updated citations.
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	2/14/2024	Added criteria for inpatient admission for the surgery. 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	3/13/2024	Reviewed, no changes
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	11/13/2024	Added requirement for Medicare review under Benefit Policy Manual. Added Medicare requirement for IOP under "background". Added link to Medicare Benefit Policy Manual Ch.6 Sect. 70.4
MM199 Out-of-Network Medical or Behavioral Health Services for Medicare Member	MA	4/10/2024	New policy
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	5/8/2024	Annual review. No criteria changes.
PM105 Brentuximab vedotin (Adcetris)	WAH CS MA D-SNP	9/11/2024	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	4/10/2024	Early update. Starting 5/1/24, patients ≤ 1 year of age will require prior authorization. For Respiratory Syncytial Virus (RSV), Prevention in an Infant with Chronic Lung Disease (CLD), added criteria regarding infants ≤ 1 year of age. Added the following covered indications as they are for infants ≤ 1 year of age which no longer requires prior authorization: RSV, Prevention in an Infant with Congenital Heart Disease; RSV, Prevention in an Infant Born Prematurely and RSV, Prevention in an Infant with Congenital Anatomic Pulmonary Abnormalities or a Neuromuscular Disorder.
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 (Erbitux)	WAH CS MA D-SNP	3/29/2024	Annual review. For penile cancer, included that the patient may have metastatic/recurrent disease. For squamous cell skin cancer, Erbitux may be used alone or in combination with carboplatin and paclitaxel, without radiotherapy, for squamous cell skin cancer.
PM116 Ado-trastuzumab emtansine (Kadcyla)	WAH CS MA D-SNP	5/8/2024	Annual Review. No changes.

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PM117 Pembrolizumab (Keytruda)	WAH CS MA D-SNP	6/12/2024	Annual revision. *Cervical cancer* : 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. *Endometrial cancer* : 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. *Esophageal and esophagogastric junction cancer* : 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). *Gastric cancer* : Updated criteria where patients with HER2 positive
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 Treprostinil (Remodulin)	WAH CS	6/12/2024	Annual review. No changes.
PM126 Natalizumab (Tysabri)	WAH CS MA D-SNP	2/28/2024	Early update. For Cascade Select and Medicare criteria: **Crohn's Disease:** Regarding the requirement that the patient has tried at least two biologics for Crohn's disease, the listing of agents was updated as follows: Zymfentra was added and it was specified that the infliximab formulation was by intravenous infusion. **Conditions Not Recommended for Approval:** Regarding the Exclusion for Concurrent Use with an Immunosuppressant Agent in Patient with Crohn's Disease, the listing of agents was updated as follows: Zymfentra and Rinvoq were added, it was specified that the infliximab formulation was by intravenous infusion, and it was clarified that Entyvio was the intravenous infusion formulation.
PM127 Panitumumab (Vectibix) solution for intravenous infusion	WAH CS MA D-SNP	5/8/2024	Annual review. No criteria changes.
PM129 Rituximab products	WAH CS MA D-SNP	11/13/2024	Annual review. No criteria changes
PM132 Trastuzumab Products	WAH CS MA D-SNP	9/11/2024	Early update. Moved Ogivri from Non-Preferred to Preferred Products. Updated criteria to note that patients could try one of Kanjinti, Trazimera, or Ogivri.
PM133 Ziv-aflibercept (Zaltrap)	WAH CS MA D-SNP	5/8/2024	Annual review. No criteria changes.

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PM134 Denosumab (Prolia)	WAH CS MA D-SNP	3/29/2024	Annual Update. No criteria changes.
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	5/8/2024	Early Update. Created criteria specifically for Medicare to cover the following indications: asthma, chronic idiopathic urticaria (chronic spontaneous urticaria), and nasal polyps.
PM142 Ocrelizuman (Ocrevus) injection for intravenous use	WAH CS MA D-SNP	3/29/2024	Early update. For Medicaid, updated criteria "C" for PPMS to be OR.
PM144 Hyaluronic acid derivatives (such as Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz/Supartz FX, Synojoynt, 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. Alyglo 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	10/9/2024	Early update. For Cascade Select and Medicare for infliximab, changed the timeframe for patients established on therapy was changed from 90 days to 3 months (for plaque psoriasis, Behcet's disease, hidradenitis suppurativa, sarcoidosis). For Cascade Select and Medicare for Cimzia, changed the timeframe for patients established on therapy was changed from 90 days to 3 months for plaque psoriasis. For Cascade Select and Medicare, added new criteria for Cosentyx intravenous formulation. For Cascade Select and Medicare for Entyvio, clarified the criteria for patients currently taking Entyvio applies to the intravenous and subcutaneous formulation. For Cascade Select and Medicare for Ilumya, changed the timeframe for patients established on therapy was changed from 90 days to 3 months and updated note for a 3 month trial of PUVA as a traditional systemic therapy. For Cascade Select and Medicare, added criteria for Omvoh. For Cascade Select and Medicare regarding Orencia, Tyenne intravenous was added to the list of Preferred Products which could have been tried prior to Orencia intravenous. A trial of Actemra subcutaneous was reworded as a trial of a tocilizumab subcutaneous product (Actemra, biosimilar) that also counts. For Medicare and Cascade Select for Actemra, updated section title from "Actemra Approved Indications" to "Tocilizumab Approved Indications".

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PM149 Antiasthmatic Monoclonal Antibodies-IL-5 Antagonists	WAH CS MA D-SNP	5/8/2024	Annual review. Added criteria for nasal polyps for the Medicaid LOB.
PM150 Complement C5 Inhibitor	CS MA D-SNP	1/10/2024	Early Update. For Atypical Hemolytic Uremic Syndrome, require that patient does not have Shiga toxin Escherichia coli-related hemolytic uremic syndrome. Updated format for criteria for Generalized Myasthenia Gravis. For Paroxsymal Nocturnal Hemoglobinuria, requirement for the patient to be at least 18 years of age applies only to Soliris; initial therapy only requires confirmation of diagnosis. Updated criteria for mat for Neuromyelitis Optica Spectrum Disorder.
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	3/29/2024	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	5/8/2024	Annual review. Radiation-Induced Neutropenia indication was removed from the policy.
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	3/29/2024	Annual review. No criteria changes.
PM159 Esketamine nasal spray (Spravato)	WAH CS MA D-SNP	3/13/2024	Annual review. No criteria changes.
PM160 Teprotumumab injection (Tepezza)	CS MA D-SNP	5/8/2024	Annual review. Removed criteria requiring history of failure, contraindication, or intolerance to corticosteroids and the criteria requiring that the e patient has been assessed as having active disease of at least moderate severity based on signs and symptoms (e.g., the degree of inflammation, degree of proptosis, presentation of diplopia, etc.). Added criteria requiring documentation thyroid levels, confirmation that the diagnosis thyroid eye disease is related to Graves' disease, documentation of a thyroid eye disease clinical activity score of 4 or greater in at least one eye, and either one of the following: presence of diplopia; provider attesting there is significant proptosis, or inadequate response, intolerance, or contraindication to intravenous glucocorticoids.
PM161 Inebilizumb injection (Uplizna)	CS MA D-SNP	11/13/2024	Annual Review. No criteria changes.
PM162 Crizanlizumab (Adakveo)	CS MA D-SNP	11/13/2024	Annual review. No criteria changes.
PM163 Burosumab (Crysvita)	CS MA D-SNP	3/13/2024	Annual Review. No criteria changes.
PM164 Cerliponase alfa (Brineura)	CS MA D-SNP	3/13/2024	Annual review. No criteria changes.
PM165 Duchenne Muscular Dystrophy gene therapy (Exondys 51, Vyondys, Viltepso)	CS MA D-SNP	11/13/2024	Annual Review. No criteria changes

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PM166 Edavarone (Radicava)	CS MA D-SNP	3/13/2024	Annual review. No criteria changes.
PM167 Elapegademase (Revcovi)	CS MA D-SNP	3/13/2024	Annual review. No criteria changes.
PM168 Emapalumab (Gamifant)	CS MA D-SNP	3/13/2024	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	3/13/2024	Annual review. No criteria changes.
PM173 Voretigene neparvovec (Luxterna)	CS MA D-SNP	3/13/2024	Annual review. No criteria updates.
PM174 Brexanolone (Zulresso)	WAH CS MA D-SNP	5/8/2024	Annual Review. No criteria changes.
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	11/13/2024	Annual Review. For Elfabrio criteria, 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	4/10/2024	Annual review. Added criteria for Benlysta for lupus nephritis and systemic lupus erythematosus based on new HCA Medical Policies for the Medicaid LOB.

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PM183 Bevacizumab	WAH CS MA D-SNP	9/11/2024	Annual review. **Hepatocellular Carcinoma:** Remove requirement that the patient has unresectable or metastatic hepatocellular carcinoma or according to the prescriber, the patient is not a surgical candidate. Added "or B" to requirement that the patient has Child-Pugh Class A or B disease. Added requirement that the patient has unresectable disease and is not a transplant candidate; OR has liver-confined disease, inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic disease; OR has metastatic disease or extensive liver tumor burden. **Non-Small Cell Lung Cancer:** Added *KRAS G12C* is not considered an actionable mutation (the tumor may be *KRAS G12C* mutation positive) to requirement that the patient is negative or unknown for actionable mutations. Removed *KRAS G12C* mutation from requirement that the tumor is positive for one of the following mutations for first-line use. **Mesothelioma:** Removed "malignant" from malignant pleural mesothelioma and malignant peritoneal mesothelioma. **Pediatric Central Nervous System Tumors:** Added pediatric medulloblastoma as an option for approval. Removed requirement that the medication is used for palliation.
PM184 Long-Acting Granulocyte Colony Stimulatin (G-CSF) Products (Pegfilgrastim and Eflapegrastim-xnst)	WAH CS MA D-SNP	11/13/2024	Annual review. No criteria changes.
PM185 Sutimlimab-jome (Enjaymo)	CS MA	7/10/2024	Annual review. No criteria updates.
PM186 Ublituximab (Briumvi®)	WAH CS MA D-SNP	3/13/2024	Early Update. Medicaid LOB criteria was updated to require patient to have 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]). For reauthorization, requests may be approved if a patient has a previously approved prior authorization with Community Health Plan of Washington.
PM187 Phesgo	WAH CS MA D-SNP	9/11/2024	Annual Review. No criteria updates
PM188 Betibeglogene autotemcel (Zynteglo™)	CS MA	10/9/2024	Early Update. Beta Thalassemia criteria is now titled, "Transfusion-Dependent Beta-Thalassemia". The following changes were made for this criteria: Patient upper age threshold was clarified to be <51 years (previously listed as ≤50 years). Regarding use of Zynteglo in the past, the criterion was changed due to the recent approval of Casgevy for this indication. It now states that the patient has not received "a gene therapy for beta-thalassemia" in the past instead of requiring that the patient has not received Zynteglo in the past. It was added that there should not be claims present for Casgevy and that if claims history is not available, the prescribing physician confirms that the patient has not previously received Casgevy (previously, this only addressed Zynteglo). In the Note, the following statement was deleted: verify through claims history that the patient has not previously received Zynteglo. The reference to matched family donor was changed to remove "family". Regarding the confirmation that the patient has a specific genotype, the phrase "by DNA analysis" was changed to "by genetic testing". In the requirements that define a patient as transfusion-dependent, the phrases "preceding enrollment" and "before enrollment" were removed. The requirement was removed that the patient has received or is planning to receive prophylaxis for hepatic veno-occlusive disease/hepatic sinusoidal obstruction syndrome before
PM189 Lecanemab (Legembi®)	CS	10/9/2024	Annual Review. Added background information. No criteria changes.
PM190 Cantharidin (Ycanth)	WAH-IMC CS	5/8/2024	New policy
PM567 Hereditary Angioedema Agents	CS MA	5/8/2024	Annual Review. No revisions

CCC Name & Link	Line of Business	Last Updated	Summary of Change
PM568 Transthyretin Amyloidosis Agents	CS MA	5/8/2024	Early Update. Added Wainua (eplontersen) to the policy.
PM569 Triamcinolone ER (Zilretta)	WAH CS MA D-SNP	5/8/2024	Annual review. No criteria changes.
PM570 Botulinum Toxins	WAH CS	1/10/2024	Early update. Added Daxxify to the policy.
PM572 Lumasiran injection (Oxlumo)	CS MA	2/28/2024	Early update. It was added under Conditions not recommended for approval that concurrent use of Oxlumo and Rivfloza should not be used.
PM573 Bimatoprost (Durysta)	CS MA	5/8/2024	Annual Review. No criteria updates
PM574 Intravitreal Corticosteroids	WAH CS MA D-SNP	5/8/2024	Annual Review. No criteria changes.
PM575 Tezepelumab (Tezspire)	WAH CS MA D-SNP	5/8/2024	Annual Review. No criteria changes.
PM576 Efgartigimod Alfa (Vyvgart)	CS MA	5/8/2024	Early Update. Added Efgartigimod Alfa and Hyaluronidase (Vyvgart Hytrulo) to the title of the policy. Specified that initial criteria is applicable to both Vyvgart and Vyvgart Hytrulo.
PM577 Alpha-Proteinase Inhibitor (Human)	WAH CS MA D-SNP	9/11/2024	Annual review. No criteria updates.
PM578 Cabotegravir (Apretude)	CS	2/14/2024	Annual review. Added reauthorization criteria for the Pre-Exposure Prophylaxis indication. Extended initial approval from 3 months to 6 months. Updated the Conditions Not Recommended for Approval to state, "Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published date are available."
PM579 Spesolimab-sbzo (Spevigo)	CS MA	5/8/2024	Annual Review. Updated age requirement to be at least 12 years of age or older. Added requirement that the patient must weigh at least 40 kg.cy
PM580 Olipudase alfa (Xenpozyme)	CS MA	5/8/2024	Annual Review. No criteria updates.
PM581 Hemophilia Products	CS MA	11/13/2024	Annual review. For Roctavian, the following changes were made: For approval, the word "single" was added before the word "dose" for clarification.; Regarding the Note in the criteria which addresses that the patient has not received Roctavian in the past (with verification in claims history required), a phrase was added to include situations in which claims history is not available.; The phrase "according to the prescribing physician" was added to the requirement that the patient has a history of use of Factor VIII therapy for at least 150 exposure days; The phrase "within 30 days before the intended receipt of Roctavian" was replaced with "within the past 30 days" regarding the requirement that Factor VIII inhibitor titer testing has been performed; The requirement was removed that the patient does not have an active acute or uncontrolled chronic infection; The phrase "liver health assessment" was replaced with "liver function testing". Also, the phrase "within 30 days before the intended receipt of Roctavian" was replaced with "within the past 30 days" regarding the liver function testing; The phrase, "within 30 days before the intended receipt of Roctavian" was replaced with "within the past 30 days" regarding the requirement that the platelet count was ≥ 100 x 10^9/L; The phrase "within 30 days before the intended receipt of Roctavian" was replaced with "within the past 30 days" regarding the requirement that the creatinine level was < 1.4 mg/dL; The requirement (along with the related Note) was removed that the patient has not used a systemic immunosuppressive agent within 30 days before intended receipt of Roctavian; The requirement was removed that the patient does not have any disease or condition that would interfere with the compliance
PM582 Panhematin (Hemin)	WAH CS MA D-SNP	6/12/2024	Annual review. No criteria updates.

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PM583 Sandostatin LAR Depot (Octreotide Intramuscular Injection) and Lanreotide	WAH CS MA D-SNP	6/12/2024	Annual review. No criteria updates.
PM584 Elranatamab-bcmm (Elrexfio)	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	11/13/2024	Annual review. No criteria changes.
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	2/28/2024	Early Update. Added "Concomitant Use with Another Neonatal Fc Receptor Blocker, a Complement Inhibitor, or a Rituximab Product". Examples of Neonatal Fc Receptor Blockers and Complement Inhibitors are listed as Notes.
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 endophalmitis. The medication will be prescribed by or in consultation with an ophthalmologist.
PM589 Ranibizumab Products	WAH CS MA D-SNP	11/13/2024	Annual review. No criteria changes
PM590 Brolucizumab (Beovu)	WAH CS MA D-SNP	11/13/2024	Annual review. No criteria changes
PM592 Beremagene Geperpavec (Vyjuvek)	CS MA	11/13/2024	Annual review. No criteria changes
PM593 Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty	CS MA	9/11/2024	Early update. Lupron Depot-Ped dosage (for each indication): Updated frequency to also include 12 weeks on the 3-month depot. Added the following dosage regimen: 6-month depot: Approve up to one 6-month depot (45 mg) given IM once every 6 months (24 weeks).
PM594 Syfovre (pegcetacoplan [intravitreal])	WAH CS MA D-SNP	2/14/2024	New policy
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