COMMUNITY HEALTH PLAN of Washington™
The power of community

Line of Business (LOB) Legend:
WAH = Washington Apple Health IMC
BHSO = Behavioral Health Services Only
CS = Cascade Select
MA = Medicare Advantage

Clinical Coverage Criteria (CCC)

Last Updated: 02/29/2024

CCC Name & Link	Line of Business	Last Updated	Summary of Change
MM125 Physical, Occupational and Speech Therapy	WAH CS MA	2/14/2024	Clarified CMS criteria for PT/OT/Speech Therapy. Added CMS criteria for initiation of Pulmonary and Cardiac Rehabilitation and for Medical Nutrition Therapy. Clarified coverage limitations for Cascade Select. Updated citations and links.
MM127 Arthroscopic Debridement or Lavage of Osteoarthritic Knee	WAH CS MA	8/31/2023	Added local coverage article A54063. Updated citations. Removed references to CHNW. Corrected links.
MM128 Orthoptic Therapy	WAH CS MA	11/2/2023	Reviewed. Citations updated.
MM129 Neuropsychological Testing	WAH CS MA BHSO	7/10/2023	Updated provider criteria for WAHIMC,BHSO, Cascade Select to reflect current SERI language. Minor updates to criteria to reflect differences between LCD and SERI criteria. Updated reference links/ added LCD link. Small grammatical edits.
MM130 Cardiac Stents	WAH CS MA	8/31/2023	Reviewed with no edits. Updated citations. Added Noridian LCA to references.
MM131 Transplants and Transplant Work-ups, Donor Search, Donation	WAH CS MA	12/13/2023	Corrected link for NCD 110.23 Stem Cell Transplantation and applied this for other lines of business. Clarified that MCG criteria apply to Medicare members requesting renal transplantation. Updated citations.
MM132 Complementary and Alternative Care	WAH CS MA	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	3/31/2023	Review, minor edits
MM135 Positive Airway Pressure Devices	WAH CS MA	9/11/2023	Added criteria for replacement of CPAP and BPAP after 5 years.
MM136 Durable Medical Equipment	WAH CS MA	2/14/2024	Added wound vac criteria for devices applied in the hospital. Updated citations.
MM139 Skilled Nursing Facility, Comprehensive Outpatient Rehab Facility	WAH CS MA	2/14/2024	Added criteria allowing SNF authorization after a 3 day medically necessary hospital stay for Medicare members. Updated citations.
MM141 Reconstructive Plastic Surgery	WAH CS MA	2/14/2024	Minor edits. Corrected links. Updated citations.
MM143 Sterilization	WAH CS MA	8/31/2023	Reviewed with minor edits. Removed references to CHNW. Corrected links. Updated citations.
MM144 Home Oxygen	WAH CS MA	12/13/2023	Clarified that Medicare criteria are found in NCD 240.2. Cluster headache criteria remain the same since they are no longer addressed by CMS. Citations updated.
MM145 Bariatric Surgery	WAH CS MA	5/22/2023	Clarified that surgeries other than lap bands can be considered for EPSDT AH members under age 21. Minor edits. Updated citations.
MM146 Tympanostomy Tubes	WAH CS MA	11/2/2023	Reviewed. Citations updated.
MM147 Enteral Therapy Products for Enrollees with Inherited Metabolic Disorders	WAH CS MA	2/14/2024	Updated links, minor edits. Updated citations.

CCC Name & Link	Line of Business	Last Updated	Summary of Change
MM148 Extracorporeal Membrane Oxygenation Therapy	WAH CS MA	11/2/2023	Verified there are no LCDs or NCDs related to this service. Reviewed and citations updated.
MM149 Spinal Injections and Facet Neurotomy	WAH CS MA	2/14/2024	Corrected LCD for Sacroiliac joint injection. Updated citations.
MM151 Nonpharmacologic Treatments for Treatment-Resistant Depression	WAH CS MA BHSO	12/8/2023	Added link to HTTC 2023 updated findings and decision on Nonpharmacologic Treatments for TRD
MM152 Intensity Modulated Radiation Therapy IMRT	WAH CS MA	6/8/2023	Clarified protection of vital structures based on feedback regarding breast cancer treatment guidelines in a peer to peer with a network board certified radiation oncologist on 5/25/2023. Corrected A58245 link. Updated citations.
MM153 Proton Beam Therapy	WAH CS MA	8/31/2023	Added LCD L37072 as a reference. Minor edits including removal of references to CHNW and updates to citations.
MM154 Applied Behavioral Analysis	WAH BHSO CS	12/20/2023	Updated required documentation and criteria to align with WACs 182-531A-0400 and 284-43-7070, added WAC references, updated BHSO section to include coverage for age 20 and younger
MM155 Wraparound with Intensive Services Program (WISe) for AH-IMC and BHSO	WAH BHSO	7/10/2023	Updated WAC and reference links, reviewed policy content
MM156 Administrative Days	WAH BHSO	2/14/2024	Minor edits. Updated citations.
MM158 Prosthetics, Orthotics, and Therapeutic Diabetic Shoes	WAH CS MA	11/2/2023	Inclusion of L33787 comment on replacement sockets and expansion on section regarding functional potential.
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 MA BHSO	12/13/2023	Removed CHNW references. Updated citations.
MM163 Hospice Care, Pediatric Concurrent Care, and Pediatric Palliative Care	WAH CS MA	12/13/2023	Minor edits and updates to citations.
MM164 Clinical Trials for Treatments and Devices	WAH CS MA BHSO	2/14/2024	Added WAC Hierarchy of Evidence. Updated citations.
MM165 Genetic Testing	WAH CS MA	9/26/2023	Added initial notes, updated background and definitions, removed references to specific gender- binary transition states, streamlined duplicated content
MM166 Gender Affirming Care	WAH CS MA	45336	Corrected that HCA covers electrolysis for AH members. Updated WPATH to SOC 8. Removed CHNW references. Updated citations.
MM167 Speech Generating Devices (Augmentative Communication Devices)	WAH CS MA	6/8/2023	Added medical necessity criteria and repair/replacement criteria for medical equipment.
MM168 Hearing Assist Devices	WAH CS MA	12/28/2023	Linked NCD for Cochlear implants for Medicare members. Clarified criteria for unilateral vs bilateral cochlear implants. Added criteria for cochlear implants for AH adults (covered benefit as of 1/1/24).
MM169 Bathroom and Toilet DME and Supplies	WAH CS MA	6/8/2023	Added Medical Necessity, DME, Repair and Replacement Criteria.
MM170 Drug Testing in Substance Use Disorder Treatment and Pain Management	WAH CS MA BHSO	2/14/2024	Link to LCD for Medicare, updated medical necessity criteria, documentation requirements, and coverage limitations by service line

CCC Name & Link	Line of Business	Last Updated	Summary of Change
MM171 Inpatient Rehabilitation	WAH CS MA	11/2/2023	Reviewed with minor edits. Citations updated.
MM172 Home Health Skilled Services	WAH CS MA	12/13/2023	Removed bladder catheters as custodial. Clarified that changing indwelling bladder catheters and suprapubic catheters is a skilled nursing activity
MM176 Psychological Testing	WAH CS MA BHSO	7/10/2023	Reviewed criteria against LCD and updated. Added LCD link, updated HCA service guide link. Minor grammatical edits.
MM177 Eating Disorders, Inpatient Behavioral Health Level of Care	WAH CS MA BHSO	7/10/2023	Updated reference link to 2023 APA guideline
MM178 Eating Disorders, Partial Hospital Behavioral Health Level of Care	WAH CS MA BHSO	7/10/2023	Updated reference link to 2023 APA Practice Guideline
MM179 Eating Disorders and Anorexia Nervosa, Residential Behavioral Health Level of Care	WAH CS MA BHSO	7/10/2023	Updated reference link to 2023 APA Practice Guideline
MM180 Electroconvulsive Therapy (ECT)	WAH CS MA BHSO	7/12/2023	Reviewed, minor edits
MM181 Repetitive Transcranial Magnetic Stimulation (rTMS)	WAH CS MA BHSO	9/6/2023	Added reference link to HTCC 2023 decision, removed psychosis as an absolute contraindication to rTMS, added smoking cessation to list of conditions with insufficient evidence for rTMS
MM182 Peripheral Nerve Blocks, Diagnostic Injections, Ablations and Electrostimulation	WAH CS MA	5/24/2023	Added requirement that treatment must be evidence based and aligned with standards of medical care. Reviewed policy. Updated citations. Minor edits.
MM183 Cervical Or Lumbar Spinal Fusion For Patients With Degenerative Disc Disease	WAH CS MA	2/14/2024	Corrected Medicare criteria to A53975. Corrected operative status criteria. Updated citations.
MM184 Pharmacogenetic Testing	WAH CS MA BHSO	10/5/2023	Minor edits. Removed CHNW. Corrected links.
MM185 Sacroiliac Joint Fusion	WAH CS MA	12/13/2023	Removed summary of LCD. Updated citations.
MM186 Hip Surgery for Femoroacetabular Impingement (FAI) Syndrome	WAH CS MA	12/13/2023	Citations updated. Verified that there is no LCD/NCD.
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	12/13/2023	Reviewed, minor edits.
MM190 Knee and Hip Arthroplasty for Osteoarthritis	WAH CS MA	2/14/2024	Added criteria for inpatient admission for the surgery. Updated citations.
MM192 Spinal Cord Stimulation for Treatment of Chronic Pain	WAH CS MA	5/24/2023	Minor edits and correction of links. Updated citations. An HTA re-review is not currently available.
MM193 New Journeys Coverage Criteria for AH-IMC and BHSO	WAH BHSO	5/23/2023	Minor edits for clarity
MM194 Intensive Behavioral Health Treatment Facility	WAH BHSO	12/8/2023	Reviewed, no changes made

CCC Name & Link	Line of Business	Last Updated	Summary of Change
MM195 Wheelchair	WAH CS MA	1/8/2024	Clarified reasonable timeframes for repair and replacement of wheelchairs. Clarified that standard wheelchairs do not need a home assessment.
MM196 Intensive Behavioral Supportive Supervision (IBSS)	WAH BHSO	12/29/2023	New policy
MM197 Mental Health Partial Hospitalization Programs (PHP)	WAH CS MA BHSO	12/29/2023	New policy
MM198 Mental Health Intensive Outpatient Programs (IOP)	WAH CS MA BHSO	12/29/2023	New policy
PM101 Hydroxyprogesterone caproate Makena injection for intramuscular use	WAH CS MA	11/22/2023	Early update. Criteria is updated to note that prevention of pre-term labor of singleton pregnancies in women with a history of spontaneous singleton preterm birth, premature labor, or premature rupture of membranes is not a covered indication. Required that the use of the medication must be consistent with standards of good medical practice and supported by evidence-based medicine as shown by an FDA approved indication.
PM103 Ipilimumab (Yervoy)	WAH CS MA	1/10/2024	Annual review. For neuroendocrine tumors and adrenal tumors, updated criteria 8bi to be that the tumor is local advanced/metastatic and classified as well-differentiated, grade 3; updated criteria 8bii to be that the tumor is unresectable/metastatic, and chemotherapy has been tried. Adding criteria for Gastric Cancer as an additional indication for Small Bowel Adenocarcinoma, Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) OR Ampullary Adenocarcinoma, MSI-H or dMMR. Added Biliary Tract Cancers, Merkel Cell Carcinoma, Head and Neck Cancers, Soft Tissue Sarcoma, and Pancreatic Adenocarcinoma as covered indications with criteria. For Hepatocellular Carcinoma, combined criteria that the patient has Child-Pugh Class A and has tried at least one tyrosine kinase inhibitor; added criteria option that the patient has advanced or metastatic tumor mutational burden-high (TMB-H), defined as >10 mutations/megabase (mut/Mb).
PM104 Pemetrexed (Alimta® and Pemfexy®)	WAH CS MA	7/6/2023	Annual review. Added criteria for head and neck cancer.
PM105 Brentuximab vedotin (Adcetris)	WAH CS MA	11/2/2023	Annual review. Guideline change to previously untreated Hodgkin lymphoma to include pediatric patients at least 2 years of age (previously indicated for adults only). Updated dosing between previously untreated and classical consolidation and relapsed Hodgkin lymphoma. Added criteria for pediatric mediastinal large B-cell lymphoma.
PM108 Pertuzumab (Perjeta)	WAH CS MA	11/2/2023	Annual review. Updated special considerations with black box warnings.
PM109 Palivizumab (Synagis)	WAH CS MA	11/6/2023	Early update. Patients ≤ 1 year of age do not require prior authorization. For Respiratory Syncytial Virus (RSV), Prevention in an Infant with Chronic Lung Disease (CLD), removed criteria regarding infants ≤ 1 year of age. Removed 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	9/7/2023	Annual review. Added criteria for endometrial cancer to require that the patient must try at least one other systemic chemotherapy. Added ampullary adenocarcinoma as a covered indication. Patients with ampullary adenocarcinoma must use albumin-bound paclitaxel in combination with gemcitabine and must have the medication prescribed by an oncologist.
PM112 Ramucirumab (Cyramza)	WAH CS MA	1/10/2024	Annual revision: Clarified the Cyramza can be used in patients that have epidermal growth factor receptor exon 21 (L858R) substitution mutations.

CCC Name & Link	Line of Business	Last Updated	Summary of Change
PM114 Epoprostenol (Flolan, Veletri), generics	WAH CS MA	11/2/2023	Annual Review. No changes
PM115 Cetuximab (Erbitux)	WAH CS MA	7/6/2023	Annual review. Added indication for BRAF V00E mutation positive metastatic CRC. CAPEOX treatment option added in CRC. FOLFOXIRI +/- cetuximab removed as a treatment option in CRC. Regimen for anti-PD-1 antibody (nivolumab/pembrolizumab) added in Head and Neck Cancer. Updated dosing for squamous cell skin cancer.
PM116 Ado-trastuzumab emtansine (Kadcyla)	WAH CS MA	7/6/2023	Annual Review. For Non-Small Cell Lung Cancer, recommended as subsequent therapy for patients with recurrent, unresectable, or metastatic disease. For salivary gland tumors, now requiring patients to say they have recurrent, unresectable, or metastatic disease.
PM117 Pembrolizumab (Keytruda)	WAH CS MA	9/7/2023	Annual revision. *Esophageal and esophagogastric junction cancer* : Added criteria to show that the patient must have tumor expression for programmed death-ligand 1 (PD-L1) as determined by an approved test that has a combined positive score (CPS) ≥ 1 or have human epidermal growth factor 2 (HER2)-positive disease and is using the medication in combination with a fluoropyrimidine (e.g., fluorouracil, capecitabine), platinum-based therapy (e.g., oxaliplatin, cisplatin), and trastuzumab. *Primary mediastinal large B-cell lymphoma* : Added criteria requiring that the patient is not using the medication in patients who require urgent cytoreductive therapy. *Urothelial carcinoma* : Added criteria option where according to the prescriber, the medication is used in combination with enfortumab vedotin in patients not eligible for cisplatin-containing chemotherapy. Added new indications/coverage criteria for the following conditions: Kaposi sarcoma, Richter's syndrome, and pediatric central nervous system cancers.
PM118 Alemtuzumab (Lemtrada)	WAH CS MA	8/29/2023	Annual review. Added criteria specifically for the Medicare LOB. Updated description on how concurrent use with other disease-modifying agents used for multiple sclerosis is not recommended.
PM119 Nivolumab (Opdivo)	WAH CS MA	1/10/2024	Annual Review. For melanoma, added requirement the patients need to be 12 years of age or older. For Hodgkin lymphoma, updated criteria to state the "The patient has had hematopoietic stem cell transplantation (HSCT) and brentuximab vedotin". Added Biliary Tract Cancers, Pancreatic Adenocarcinoma, Soft Tissue Sarcoma as covered indications with each of their own criteria.
PM122 Treprostinil (Remodulin)	WAH CS	9/7/2023	Annual review. Added Tadliq (tadalafil oral suspension) as an example of an oral agent for pulmonary arterial hypertension (PAH). Added Tyvaso DPI (treprostinil oral inhalation powder) as an example of an inhaled prostacyclin product for PAH Removed requirement to send cases to the medical director in cases where the patient is currently receiving Remodulin and does not meet criteria 1Bi or if there is insufficient information available. Updated background information. Added the following condition not recommended for approval: concurrent use with parenteral epoprostenol products, oral prostacyclin products, or inhaled prostacyclin agents used for pulmonary hypertension. Removed appendix A regarding classification of pulmonary arterial hypertension. Created criteria to require patients try generic treprostinil prior to using brand Remodulin.
PM126 Natalizumab (Tysabri)	WAH CS MA	11/22/2023	Early update. 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 the Medicare criteria.
PM127 Panitumumab (Vectibix) solution for intravenous infusion	WAH CS MA	7/6/2023	Annual review. No criteria changes.

CCC Name & Link	Line of Business	Last Updated	Summary of Change
PM129 Rituximab products	WAH CS MA	1/10/2024	Early update. Antineutrophil Cytoplasmic Antibody (ANCA)-Associated Vasculitis: Dosing was updated to specify a total of four doses for initial therapy. For follow up treatment, a total of six doses was specified for patients > 18 years of age and two doses for patients < 18 years of age. Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitors: This condition of approval was added. Multiple Sclerosis: For initial therapy, trial of at least one other disease-modifying agent was changed to require a trial of at least two other disease-modifying agents. Neuromyelitis Optica Spectrum Disorder: A total of four weekly doses for a regimen of 375 mg/m2 intravenous was specified
PM132 Trastuzumab Products	WAH CS MA	1/10/2024	Early update. Added "Tukysa (tucatinib tablets)" as one of the agents that can be used in combination with trastuzumab.
PM133 Ziv-aflibercept (Zaltrap)	WAH CS MA	7/6/2023	Annual review. Removed requirement that the patient should not have been previously treated with FOLFIRI.
PM134 Denosumab (Prolia)	WAH CS MA	5/4/2023	Annual Update. Formatting changes. No criteria changes.
PM135 Denosumab (Xgeva)	WAH CS MA	11/2/2023	Annual review. Updating Medicare line of business (LOB) to require Xgeva to be reviewed under Local Coverage Determination (LCD) Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications (L33270) in some indications while reviewing for under indications under this policy.
PM136 Epoetin Products	WAH CS MA	12/18/2023	Early update. Added description noting that the policy incorporates Medicare coverage guidance as set forth in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
PM138 Ibandronate (Boniva)	WAH CS MA	9/7/2023	Annual review. No revisions.
PM139 Immune globulin subcutaneous	WAH CS MA	1/10/2024	Early update. Removed age criteria for HyQvia.
PM140 Darbepoetin alfa (Aranesp)	WAH CS MA	12/18/2023	Early update. Added description noting that the policy incorporates Medicare coverage guidance as set forth in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
PM141 Omalizumab (Xolair) injection for subcutaneous use	WAH CS MA	7/6/2023	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	8/29/2023	Annual review. Added criteria specifically for the Medicare LOB. Updated description on how concurrent use with other disease-modifying agents used for multiple sclerosis is not recommended.
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	9/7/2023	Annual review. SynoJoynt was added to the policy. For Medicare, Monovisc, Orthovisc, Synvisc, and Synvisc One are listed as preferred products, while Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Supartz FX, Sodium hyaluronate injection, SynoJoynt, Triluron, TriVisc, Visco-3 are listed as non-preferred products. Criteria for Medicare was updated to be the same as the criteria for Medicaid and Cascade Select.
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	12/18/2023	Early update. Added Medicare line-of-business to be included in this policy. Updated criteria in certain indications (e.g., B-Cell Chronic Lymphocytic Leukemia for Prevention of Infections; Hematologic Neoplasm-Associated Hypogammaglobulinemia or Hypogammaglobulinemia after B-cell Targeted Therapies (Secondary Immunodeficiency); Hematopoietic Cell Transplantation to Prevent Infection: updated patient's immunoglobulin G (IgG) level to be <600 mg/dL (6.0 g/dL); previously was 500 mg/dL (5.0 g/dL). Separated criteria from Medicaid/Cascade Select and Medicare. Added autoimmune retinopathy as a covered indication for Medicare.

CCC Name & Link	Line of Business	Last Updated	Summary of Change
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	1/10/2024	Early update. Actemra intravenous was moved from Non-Preferred to Preferred.
PM149 Antiasthmatic Monoclonal Antibodies-IL-5 Antagonists	WAH CS MA	7/6/2023	Early Update. Created criteria specifically for Medicare to cover the following indications: asthma, eosinophilic Granulomatosis with Polyangiitis (Nucala only), hypereosinophilic syndrome (Nucala only), and nasal polyps (Nucala only).
PM150 Complement C5 Inhibitor	MA CS	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	11/2/2023	Annual review. PA is no longer required for Sublocade for the Medicaid LOB.
PM152 Enzymes for Gaucher Disease	CS MA	1/10/2024	Early update. Updated criteria to only require that the patient has Type 1 Gaucher disease, confirmation of the diagnosis by having one of the following: demonstration of deficient β-glucocerebrosidase activity in leukocytes or fibroblasts OR molecular genetic testing documenting glucocerebrosidase gene mutation, and requiring the medications to be prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders. Dosing limits for Cerezyme is updated to not exceed 60 U/kg no more frequently than three times per week. Cerezyme is moved to a preferred product. Elelyso and Vpriv are moved to non-preferred products.
PM153 Romiplostim (Nplate)	WAH CS MA	5/4/2023	Annual Review. Formatting changes. No criteria changes.
PM154 Corticotropin (H.P. Acthar Gel)	WAH CS MA	1/10/2024	Early update. Created separate criteria for Cascade Select and Medicare
PM155 Filgrastim Products	WAH CS MA	6/30/2023	Early update. New criteria added to apply to Medicare LOB for filgrastim products. Changed preferred products for Medicare to be Nivestym and Zarxio. Granix, Neupogen, and Releuko are non-preferred for Medicare.
PM157 Afamelanotide implant (Scenesse)	CS MA	1/10/2024	Annual Review. No criteria change.
PM158 Capacizumab injection (Cablivi)	WAH CS MA	5/4/2023	Annual review. Provided additional information to the dosing criteria. No criteria changes.
PM159 Esketamine nasal spray (Spravato)	WAH CS MA	5/4/2023	Annual Review. Added Limitations of Use information from the package insert to the “Conditions Not Recommended for Approval” section. No criteria changes.criteria changes.
PM160 Teprotumumab injection (Tepezza)	CS MA	7/6/2023	Annual review. Updated dosing criteria to specify the dosing strength for the initial dose and the dosing strength for the additional doses.
PM161 Inebilizumb injection (Uplizna)	CS MA	1/10/2024	Early update. Added a note to show that trying and failing Soliris or Enspryng for neuromyelitis optica spectrum disorder will count as an exception to a trial of a systemic therapy. Added criteria for patients currently receiving Uplizna.
PM162 Crizanlizumab (Adakveo)	CS MA	5/4/2023	Annual review. No criteria changes.
PM163 Burosumab (Crysvita)	CS MA	5/4/2023	Annual Review. No criteria changes.
PM164 Cerliponase alfa (Brineura)	CS MA	5/4/2023	Annual review. No criteria changes.

CCC Name & Link	Line of Business	Last Updated	Summary of Change
PM165 Duchenne Muscular Dystrophy gene therapy (Exondys 51, Vyondys, Viltepso)	CS MA	1/10/2024	Annual Review. Added criteria for delandistrogene moxeparvovec (Elevidys).
PM166 Edavarone (Radicava)	CS MA	5/4/2023	Annual review. No criteria changes.
PM167 Elapegademase (Revcovi)	CS MA	5/4/2023	Annual review. Changed verbiage in criteria.
PM168 Emapalumab (Gamifant)	CS MA	5/4/2023	Annual review. No criteria changes
PM169 Givosiran (Givlaari)	CS MA	1/10/2024	Early Update. Added criteria to require that the patient demonstrated clinical features associated with acute hepatic porphyria and that the patient has elevated urinary aminolevulinic acid greater than the upper limit of normal or elevated urinary porphobilinogen greater than the upper limit of normal. Changed the requirement of having a history of two porphyria attacks in the last 6 months to one porphyria attack.
PM170 Nusinersen (Spinraza)	CS MA	1/10/2024	Early update. Updated criteria requiring different motor ability assessment, genetic test confirming diagnosis, documentation of survival motor neuron 2 gene copies, signs consistent with spinal muscular atrophy, confirmation that therapy with Evrysdi will be discontinued, and that the medication is prescribed by a physician who has consulted with or who specializes in the management of patients with spinal muscular atrophy and/or neuromuscular disorders.
PM171 Onasemnogene abeparvovec (Zolgensma)	CS MA	1/10/2024	Early Update. Updated genetic test confirmation, number of survival motor neuron, lifer function assessment criteria. Added criteria requiring renal function, complete blood count, discontinuing Evrysdi, and a physician who has consulted with or specializes in the management of patients with spinal muscular atrophy and/or neuromuscular disorders.
PM172 Pegvaliase (Palynziq)	CS MA	5/4/2023	Annual review. No criteria changes.
PM173 Voretigene neparvovec (Luxterna)	CS MA	5/4/2023	Annual review. No criteria updates.
PM174 Brexanolone (Zulresso)	WAH CS MA	7/6/2023	Annual Review. No criteria changes.
PM175 Calcitonin Gene-Related Peptide Inhibitors (i.e.: Eptinezumab (Vyepti)) Clinical Coverage Criteria	WAH CS MA	1/10/2024	Annual update. Created different criteria for Medicare and Cascade Select. Patients must be at least 18 years of age, have at least 4 migraine headache days per month (prior to initiating a migraine-preventative medication), try at least two prophylactic pharmacologic therapies from different pharmacologic classes, had an inadequate response or adverse event from prophylactic pharmacologic therapies, and if currently taking Vyepti, had a significant benefit from the medication.
PM176 Enzyme replacement therapy	WAH CS MA	1/10/2024	Annual Review. Added Elfabrio and Lamzede to the policy with criteria.
PM177 Gonadotropin-Releasing Hormone Agonist Therapy for Gender Dysphoria	WAH-IMC CS MA	11/2/2023	Annual review. No changes
PM180 Cabotegravir/rilpivirine (Cabenuva)	CS MA	9/7/2023	Annual review. Updated age requirement to include patients at least 12 years of age. Added criteria to require patients be at least 35 kg. Reworded criteria to show that an oral lead-in with oral cabotegravir and oral rilpivirine is optional.
PM181 Inclisiran (Leqvio)	WAH-IMC CS MA	1/10/2024	Annual review. Updated background information. Updated indications to now cover atherosclerotic cardiovascular disease, heterozygous familial hypercholesterolemia, and primary hyperlipidemia. Medicaid member must now have a history of failure, contraindication, or intolerance to Repatha. Cascade Select and Medicare members must now try and fail either Repatha or Praluent.
PM182 Anifrolumab (Saphnelo) and Belimumab (Benlysta)	WAH-IMC CS MA	8/29/2023	Early update. New criteria set for Saphnelo for systemic lupus erythematosus. Added Benlysta to the policy, which is covered for lupus nephritis and systemic lupus erythematosus. Policy title it updated to “Anifrolumab (Saphnelo) and Belimumab (Benlysta) Clinical Coverage Criteria”

CCC Name & Link	Line of Business	Last Updated	Summary of Change
PM183 Bevacizumab	WAH-IMC CS MA	11/2/2023	Annual review. Added criteria for pediatric central nervous system tumors and ampullary adenocarcinoma. Added criteria for all indications to require patients to be at least 18 years of age (with the exception of pediatric central nervous system tumors. For non-small cell lung cancer, added requirement that the patient does not have a history of recent hemoptysis and updated criteria regarding tumor mutations. For hepatocellular carcinoma, a requirement was added that the patient has Child-Pugh Class A disease. For colon and rectal cancer, appendiceal was added to the condition of approval. For central nervous system tumors, astrocytoma and oligodendroglioma were added as additional optionals for approval. Additional minor descriptors were updated throughout indications. For mesothelioma, bevacizumab was removed if used as a single agent for maintenance therapy as an option of approval. Dosing regimens were changed for endometrial cancer and vulvar cancer. For small bowel adenocarcinoma, requirement was added that the patient has advanced or metastatic disease. For cervical cancer, the option of approval was added that the patient has persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix. Added Vegzelma to the covered drug list as a non-preferred product for all LOBs.
PM184 Long-Acting Granulocyte Colony Stimulatin (G-CSF) Products (Pegfilgrastim and Eflapegrastim-xnst)	WAH-IMC CS MA	1/10/2024	Early Update. Separated criteria for Rolvdeon from products for Medicare. For Medicare, Ziextenzo has been moved to a non-preferred product, and Nyvepria has been moved to a preferred product.
PM185 Sutimlimab-jome (Enjaymo)	CS MA	9/7/2023	Annual review. No criteria updates.
PM186 Ublituximab (Briumvi®)	WAH-IMC CS MA	9/26/2023	New policy
PM187 Phesgo	WAH-IMC CS MA	12/21/2023	New policy
PM188 Betibeglogene autotemcel (Zynteglo™)	CS MA	12/21/2023	New policy
PM189 Lecanemab (Legembi®)	CS	12/21/2023	New policy
PM567 Hereditary Angioedema Agents	CS MA	7/6/2023	Annual Review. No revisions
PM568 Transthyretin Amyloidosis Agents	CS MA	1/10/2024	Early Update. Added Tegsedi (inotersen) to the policy.
PM569 Triamcinolone ER (Zilretta)	WAH CS MA	7/6/2023	Annual review. Updating background information to update American College of Rheumatology Guidelines.
PM570 Botulinum Toxins	WAH CS	1/10/2024	Early update. Added Daxxify to the policy.
PM572 Lumasiran injection (Oxlumo)	CS MA	7/6/2023	Annual Review. Removed criteria requiring trial and failure of potassium citrate and magnesium oxide. Rephrased wording of requiring a genetic test to confirm disease. Provided other lab values that the patient can meet for approval. Required patients to not have received a liver transplant for primary hyperoxaluria type 1. Updated dosing regimen criteria.
PM573 Bimatoprost (Durysta)	CS MA	7/6/2023	Annual Review. Added additional criteria requiring that the patient does not have a posterior lens capsule that is absent or ruptured due to the risk of implant migration into the posterior segment.
PM574 Intravitreal Corticosteroids	WAH CS MA	7/6/2023	Annual Review. No criteria changes.
PM575 Tezepelumab (Tezspire)	WAH CS MA	7/6/2023	Annual Review. Created new criteria specifically for Medicare. New criteria for Medicare lists Tezspire as a preferred product for monoclonal antibodies used for asthma
PM576 Efgartigimod Alfa (Vyvgart)	CS MA	1/10/2024	Early update. Added Vyvgart Hytrulo to the policy

CCC Name & Link	Line of Business	Last Updated	Summary of Change
PM577 Alpha-Proteinase Inhibitor (Human)	WAH CS MA	11/2/2023	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	7/3/2023	New policy
PM580 Olipudase alfa (Xenpozyme)	CS MA	7/3/2023	New policy
PM581 Hemophilia Products	CS MA	1/10/2024	Early Update. Added Roctavian to the policy.
PM582 Panhematin (Hemin)	WAH CS MA	8/7/2023	New policy
PM583 Sandostatin LAR Depot (Octreotide Intramuscular Injection) and Lanreotide	WAH CS MA	8/7/2023	New policy
PM584 Elranatamab-bcmm (Elrexfio)	WAH CS MA	1/10/2024	New policy
PM585 Gonadotropin-Releasing Hormone Agonists – Injectable Long-Acting Products	WAH CS MA	1/10/2024	New policy
PM586 Faricimab-svoa (Vabysmo)	WAH CS MA	1/10/2024	New policy
PM587 Rozanolixizumab-noli (Rystiggo)	CS MA	1/10/2024	New policy
PM588 Ranibizumab (Susvimo)	WAH CS MA	1/10/2024	New policy
PM589 Ranibizumab Products	WAH CS MA	1/10/2024	New policy
PM590 Brolucizumab (Beovu)	WAH CS MA	1/10/2024	New policy
PM591 Aflibercept (Eylea and Eylea HD)	WAH CS MA	1/10/2024	New policy
PM592 Beremagene Geperpavec (Vyjuvek)	CS MA	1/10/2024	New policy
PM593 Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty	CS MA	1/10/2024	New policy
PM594 Syfovre (pegcetacoplan [intravitreal])	WAH CS MA	2/14/2024	New policy