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Policy Notice for Our Network Providers

October 1, 2023

Our health plan has just approved the **medical policies** and **medical benefit drug policies** outlined in this notification. Please share this information with those in your organization who may be affected by these updates.

Information in this notification is applicable to all of our health plan's products, unless otherwise specified in the policy.

We're Merging Monthly Policy Notices With Our 'Provider News'

Starting in November 2023, these monthly Policy Notices for network providers will be part of our new monthly health plan *Provider News* (published quarterly today). Expect the same monthly policy information from this notice but packaged as part of our new *Provider News* — which will continue to be published on **our website** as well.

Medical Policy Updates

See our online **Document Library** for current medical policies and those with future effective dates. To verify when a policy is or will be in effect, please refer to the effective date listed at the end of each policy.

Medical Policies – Retired

Effective January 1, 2024:

- **Sleep Studies: Unattended (Home) Sleep Studies and Nocturnal Polysomnography, Multiple Sleep Latency Testing and Maintenance of Wakefulness Testing** (MP9132) — Replaced by **Facility-Based Polysomnography, Adults (Sleep Study)** (MP9676)
- **Speech Therapy (Rehabilitative/Habilitative)** (MP9171)
- **Therapeutic Contact Lens** (MP9201)
- **Skilled Nursing Facility (**MP9310) — Replaced by **Skilled Nursing Facility** (MP9670)
- **Sacroiliac (SI) Joint Injections** (MP9466)
- **Speech Generating Device** (MP9523) — Device/procedure not covered.
- **Percutaneous Interspinous Spacer (VertiFlex®)** (MP9544) — Device/procedure not covered.
- **Vertos Minimally Invasive Lumbar Decompression (MILD)** (MP9551) — Device/procedure not covered.

- **Eustachian Tube Dysfunction (Acclarent AERA)** (MP9604) — Device/procedure not covered.

Medical Policies – Prior Authorization Removed

Effective December 1, 2023:

- **Epidural Steroid Injection (ESI) and Selective Nerve Root Block (SNRB)** (MP9362)

Effective January 1, 2024:

- **Home Health**
- **Occupational Therapy (OT)**
- **Physical Therapy (PT)**
- **Temporomandibular Disease Services** (MP9272)
- **Hospice Services** (MP9299)
- **Habilitation Services and Devices** (MP9443)

Medical Policies – Experimental and Investigational (Not covered)

Services listed for policies in this section are not covered as they are considered experimental and investigational.

Effective January 1, 2024:

- **Non-covered Medical Procedures and Services** (MP9415)
  - Eustachian tube balloon dilation (e.g., Acclarent AERA®) for treatment of chronic eustachian tube dysfunction and all other indications.
  - Female external urinary catheter for the management of urinary incontinence (e.g., PureWick™, PrimaFit®).
  - mild® Procedure (e.g., mild® Device Kit, Vertos Medical Inc.) for the treatment of lumbar spinal stenosis and all other indications.
  - Motion-preserving interspinous/interlaminar decompression/stabilization distraction devices (includes Superion [Vertiflex™], XStop, Coflex, DIAM and Wallis) for all indications.

New Medical Policies

Services listed for policies in this section may be covered (considered medically necessary) or non-covered (considered experimental and investigational). Coverage may vary according to the terms of the member's Certificate or Summary Plan Description (SPD). For medical necessity criteria, refer to MCG™ Care Guidelines, 27th edition, 2023. Members may contact the health plan's Customer Care Center at the phone number listed on their member ID card with questions about coverage. Providers with questions about these policies may contact the Customer Care Center at 1 (800) 279-1301. Review of services will occur prior to admission, concurrently or retrospectively to determine if medical necessity criteria are met. Prior authorization is required for admission and continued stay for all of the following.

Effective January 1, 2024:

- **Inpatient Rehabilitation Facility (Acute Rehabilitation)** (MP9668)
- **Long-Term Acute Care Hospital (LTACH)** (MP9669)
- **Skilled Nursing Facility** (MP9670) — Skilled nursing facility includes an extended care facility, hospital swing bed and transitional care unit. Swing bed will only be considered

for coverage if a skilled nursing facility bed is not available or if the skilled nursing facility cannot meet the member's needs.

- **Inpatient (Hospital) Level of Care** (MP9671) — Elective inpatient admission requires prior authorization a minimum of 7-10 days prior to the procedure or admission. Notification of all inpatient admissions is required as specified in the hospital participation agreement, provider contracts and/or provider manuals. All inpatient admissions (including urgent/emergent) are reviewed for medical necessity.
- **Facility-Based Polysomnography, Adults (Sleep Study)** (MP9676) — Prior authorization is required for facility-based studies for members 18 years of age or older. Prior authorization is not required for home-based or facility-based studies for members less than 18 years of age. Continuous positive airway pressure (CPAP) titration is a covered benefit.
- **Sleep Studies for Initial Diagnosis of Obstructive Sleep Apnea** (MP9673) — Prior authorization is required for facility-based studies for members 18 years of age or older. Prior authorization is not required for home-based or facility-based studies for members less than 18 years of age. This policy includes criteria for facility-based sleep studies for children and adolescents and home sleep studies for adults.
- **Orthognathic Surgery** (MP9651) — Considered medically necessary in the presence of a facial skeletal deformity and one of the following: chewing and swallowing dysfunction, speech deficits or moderate to severe obstructive sleep apnea (OSA). Maxillomandibular advancement surgery and mandibular osteotomy are considered medically necessary for: OSA, when performed with cleft palate repair or craniofacial anomaly complex repair. Prior authorization is required.
- **Trigger Point Dry Needling** (MP9672) — Considered experimental and investigational, and therefore not covered.
- **Kidney Transplantation** (MP9675) — Kidney transplant evaluation is considered medically necessary when the member has chronic kidney disease, advanced chronic renal failure, or symptomatic uremia. Prior authorization is required for transplant evaluation, transplantation, and retransplantation.

Medical Policy Revisions

Services listed in this section may be covered (considered medically necessary) or non-covered (considered experimental and investigational).

Effective September 1, 2023:

- **Home Use of Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) for Sleep Apnea** (MP9239) — Rental or purchase of a device is required to be ordered by a physician or advanced practitioner.

Effective October 1, 2023:

- **Wireless Capsule Endoscopy (CE) and Capsule Technology to Verify Patency Prior to Capsule Endoscopy** (MP9626) — Considered medically necessary as a diagnostic imaging tool for refractory celiac disease.

Effective January 1, 2024:

- **Durable Medical Equipment (DME)** (MP9347) — Devices and/or services are covered according to the terms of the member's Certificate or Summary Plan Description (SPD). Written prescription and confirmation of member receipt is required.

- **Spinal Cord and Dorsal Root Ganglion Stimulation for Treatment of Pain** (MP9430) — Spinal cord stimulation trial or permanent implantation requires prior authorization. A 3-day trial with at least a 50% pain reduction is required. Spinal cord stimulation of the dorsal column for treatment of intractable pain and dorsal root ganglion (DRG) stimulation for the treatment of pain are considered experimental and investigational, and therefore not covered.
- **Facet Joint Injections and Percutaneous Denervation Procedures (Radiofrequency and Laser Ablation) for Facet-Mediated Joint Pain** (MP9448) — Occipital and genicular nerve radiofrequency ablation is considered experimental and investigational, and therefore not covered. Ablation/denervation of sacroiliac (SI) joint by any method is considered experimental and investigational, and therefore not covered.
- **Responsive Cortical Stimulation** (MP9496) — Considered medically necessary for the treatment of localized focal epilepsy when using a device approved by the U.S. Food and Drug Administration (FDA) for members 18 years of age or older with all of the following indications: a diagnosis of 1 or 2 well-identified localized seizure foci; currently have an average of at least 3 disabling seizures per month over the prior consecutive 3 months; and seizures are refractory to 2 or more antiepileptic medications.
- **Bone Cartilage Ligament Graft Substitutes, and Blood Derived Products for Orthopedic Applications** (MP9545) — Synthetic cartilage implants for the first metatarsophalangeal joint are considered experimental and investigational, and therefore not covered.
- **Elastography** (MP9562) — Psoriasis is no longer a covered indication for members who are receiving therapy with methotrexate.
- **Outpatient and Inpatient Electroconvulsive Therapy (ECT)** (MP9570) — Multiple-seizure ECT is considered not medically necessary, and therefore not covered.
- **Genetic Testing Medical Policies for Oncology** — Concert Genetics, our contracted vendor for genetic testing, has revised indications, minimum gene lists, reference tables, test examples, Current Procedural Terminology (CPT®) codes, and National Comprehensive Cancer Network (NCCN) criteria for the following.
  - **Oncology: Algorithmic Testing** (MP9605) — New clinical criteria and test category based on the intended use of the Breast Cancer Index. Addition of life expectancy and adverse pathologic feature requirements consistent with NCCN Guidelines for prostate cancer treatment and prognostic tests.
  - **Oncology: Cytogenetic Testing** (MP9607) — Addition of new tumor types in the clinical criteria consistent with NCCN Guidelines.
  - **Oncology: Molecular Analysis of Solid Tumors and Hematologic Malignancies** (MP9608) — Addition of new clinical criteria resulting in new test categories consistent with NCCN Guidelines for hematologic malignancies, solid tumor and RNA fusion panels. Addition of a minimum gene list for colorectal cancer.
  - **Oncology: Circulating Tumor DNA and Tumor Cells (Liquid Biopsy)** (MP9609) — Coverage added for certain stages and pathologies of breast cancer, progression of certain lung cancer tumor pathologies, and reoccurrence of certain melanoma tumor pathologies.

Medical/Pharmacy Benefit Drug Policy Updates

Our health plan requires providers to obtain prior authorization approval on all drugs with documented policies. Authorization requests should be submitted to either the health plan or Navitus as noted in the policy. Please note that most drugs require specialists to prescribe and

request authorization. Please email questions about drug policy updates to DHP.PharmacyServices@deancare.com.

Pharmacy Drug Formulary Maintenance

Effective for dates of service on and after November 1, 2023:

- **Aerochamber devices for inhalers** — Allowed coverage of both prescription and over-the-counter (OTC) versions the same as preferred brand.
- **Clindamycin phosphate** 2% vaginal cream**, Tinidazole** 500 mg tablet, **Clindesse (clindamycin phosphate)** 2% one-dose vaginal cream, **Xaciato (clindamycin phosphate)** 2% vaginal gel:
  - **Clindamycin** vaginal cream: Added quantity limit (1 tube/fill).
  - **Clindesse:** Moved to preferred brand; quantity limit (1 tube/fill) stayed the same.
  - **Tinidazole:** Moved to preferred generic tier.
  - **Xaciatio:** Moved to preferred brand tier and quantity limit (1 tube/fill).
- **Ingrezza (valbenazine)** 40 mg & 80 mg capsule 28-day supply titration pack — Added coverage with prior authorization requirement, preferred brand tier, and quantity limit (1 pack per 28 days).

Effective for dates of service on and after January 1, 2024:

- **Asthma inhalers for 2024:**
  - **Advair HFA Diskus**: Moved to not covered.
  - **Budesonide/formoterol** inhaler: Moved to non-preferred generic tier.
  - **Flovent HFA:** Moved to not covered.
  - **Fluticasone HFA** inhaler 44 mcg/act, 110 mcg/act, 220 mcg/act: Moved to non-preferred generic tier.
  - **Fluticasone/salmeterol** inhaler: Moved to non-preferred generic tier.
  - **Symbicort**: Moved to not covered.
  - **Wixela** inhaler: Moved to non-preferred generic tier.
- **Pegfilgrastim products (Neulasta and biosimilars):**
  - **Fulphila:** Stayed at preferred brand/specialty tier.
  - **Nyvepria:** Moved to preferred brand/specialty tier.
  - **Ziextenzo & others:** Moved to not covered.

Pharmacy Drug New or Expanded Formulations

Effective for dates of service on and after November 1, 2023:

- **Hydrocortisone** 2% external therapy pack shampoo and body wash — Moved to not covered.
- **Lyuzeh (latanoprost PF)** 0.005% ophthalmic solution — Moved to not covered.
- **Nitrofurantoin** 50 mg/5 mL suspension for cystitis — Moved to not covered.
- **Theophylline** 100 mg & 200 mg ER 12-hour tablets — Moved to preferred brand tier.

Pharmacy Drug New Indications

Effective for dates of service on and after November 1, 2023:

- **Ingrezza (valbenazine)** 40, 60 & 80 mg capsules — Added new indication to prior authorization criteria for adults with chorea associated with Huntington's disease.

- **Prevymis (letermovir)** 240 & 480 mg tablets — Updated approval duration and quantity limit (200 tabs/365 days).

Pharmacy Prior Authorization Form Updates

Effective for dates of service on and after November 1, 2023:

- **Nexlizet (bempedoic acid/ezetimibe) and Nexletol (bempedoic acid)** — Removed step therapy for required ezetimibe trial.

Pharmacy Drug Miscellaneous Updates

Effective for dates of service on and after November 1, 2023:

- **Naloxone** 4 mg/0.1 mL nasal spray — Added coverage of OTC formulations to standard base coverage and preferred generic tier.
- **Narcon** nasal spray — Added coverage of OTC formulations to standard base coverage and preferred generic tier.
- **Opvee (nalmefene)** 2.7 mg/0.1 mL nasal spray — Added to preferred brand tier.

New Medical Benefit Drug Policies

Effective for dates of service on and after December 1, 2023:

- **Daxxify *(*daxibotulinumtoxinA)** — New medical policy and prior authorization is not required.
- **Elrexfio (elranatamab-bcmm)** — New medical policy and prior authorization is required.
- **Izervay (avacincaptad pegol)** — New medical policy and prior authorization is required.
- **Lantidra (donislecel-jujn)** — New medical policy and prior authorization is required.
- **Roctavian (valoctocogene roxaparvovec-rvox)** — New medical policy and prior authorization is required.
- **Rystiggo (rozanolixizumab-noli)** — New medical policy and prior authorization is required.
- **Talvey (talquetamab-tgvs)** — New medical policy and prior authorization is required.
- **Veopoz (pozelimab-bbf)** — New medical policy and prior authorization is required.

Effective for dates of service on and after January 1, 2024:

- **Kimmtrak (tebentafusp-tebn)** — New medical policy and prior authorization is required.

Changes to Medical Benefit Drug Policies

Effective for dates of service on and after October 1, 2023:

- **Benlysta (belimumab)** — Changed initial and continuation coverage duration, and added clarification information for prior authorization criteria.
- **Bortezomib (Velcade, bortezimab)** — New J-Code J9051 added.
- **Cabazitaxel (Jevtana, cabazitaxel)** — New J-Code J9064 added.
- **Epoetin alfa (Epogen, Procrit, Retacrit)** — Further clarified that preferred product Retacrit does not require prior authorization.

Effective for dates of service on and after October 27, 2023:

- **Oncology policies with Magellan Rx** — The medical benefit drug policy documents for the following drugs will be updated and accessible via the "Medical Oncology Drugs" link on our Medical Management web page:
  - **Adcetris (brentuximab vedotin)**
  - **Aflibercept (Eylea, Eylea HD)**
  - **Bavencio (avelumab)**
  - **Bevacizumab (Avastin, Mvasi, Zirabev, Alymsys, Vegzelma)**
  - **Cerezyme (imiglucerase)**
  - **Cyramza (ramucirumab)**
  - **Darzalex (daratumumab)**
  - **Elelyso (taliglucerase alfa)**
  - **Erbitux (cetuximab)**
  - **Gazyva (obinutuzumab)**
  - **Hemophilia Products Factor VIII (Advate, Adynovate, Afstyla, Eloctate, Hemofil M, Koate/Koate Dvi, Kogenate Fs, Kovaltry, Novoeight, Nuwiq, Obizur, Recombinate, Xyntha/Xyntha Solofuse, Jivi, Esperoct, Altuviiio)**
  - **Imfinzi (durvalumab)**
  - **Imjudo (tremelimumab-actl)**
  - **Kadcyla (ado-trastuzumab emtansine)**
  - **Keytruda (pembrolizumab)**
  - **Libtayo (cemiplimab-rwlc)**
  - **Opdivo (nivolumab)**
  - **Opdualag (nivolumab relatlimab-rmbw)**
  - **Paclitaxel Albumin-Bound (Abraxane, paclitaxel albumin-bound)**
  - **Pemetrexed (Alimta, Pemfexy, Pemetrexed)**
  - **Perjeta (pertuzumab)**
  - **Rituximab (Rituxan, Truxima, Ruxience, Riabni)**
  - **Saphnelo (anifrolumab-fnia)**
  - **Soliris (eculizumab)**
  - **Tecentriq (atezolizumab)**
  - **Trastuzumab (Herceptin, Ogivri, Kanjinti, Trazimera, Herzuma, Ontruzant)**
  - **Ultomiris (ravulizumab-cwvz)**
  - **Vectibix (panitumumab)**
  - **Vpriv (velaglucerase alfa)**
  - **Vyvgart IV (efgartigimod alfa-fcab)**
  - **Yervoy (ipilimumab)**

Effective for dates of service on and after January 1, 2024:

- **Colony Stimulating Factors – Pegfilgrastim (Neulasta, Fulphila, Udenyca, Ziextenzo, Nyvepria, Eylnetra, Stimufend)** — Preferred product switch from Ziextenzo to Nyvepria.
- **Site of Service** (MB2206) — Updated list of drugs available for site of service.

As a reminder: Providers are encouraged to refer to **the Magellan Rx website** for a complete list of co-branded policies. In addition to co-branding and reformatting, some policies *will also be revised for new criteria* effective October 1, 2023. Providers should review the policies as there may be changes to authorization criteria and/or length of authorization that may affect a provider's care plan for a patient. For example, some drugs that previously had approval periods of 12 months may be approved for a shorter period of time, and may or may not be renewed upon review according to clinical indication.

Locating Medical Policies & Medical Benefit Drug Policies

The Prevea360 Health Plan Document Library is an online repository of medical policies, medical benefit drug policies, forms, manuals, and other documents.

Providers are encouraged to track updates and review policies in their entirety. The Prevea360 Health Plan Document Library is directly accessible at **prevea360.com/document-library** or by visiting **prevea360.com** and following the step-by-step instructions below:

- Select **Providers,** and then **Medical Management**.
- Under Policies, click the **Medical Policies** or **Drug Policies** link.
- From the Document Library page, for best results, in the **By Audience** dropdown, select **Provider** and in the **By Category** dropdown, select either **Medical Policies** or **Drug Policies**, as applicable.
- In the **Search for** field, enter the policy name or numerical digits of the assigned policy number (e.g., entering 1234 of the medical benefit policy number MB1234) and click **Go** to access the policy.

Oncology and oncology-related medical benefit drug policies that have been developed by our vendor Magellan Rx are available via links in our Medical Injectables list, not the Document Library.

Locating Pharmacy Benefit Drug Policies

Pharmacy benefit drug policies are not in the Document Library. Criteria for pharmacy benefit medications are found on the associated prior authorization forms located in the Navitus Prescriber Portal at **prescribers.navitus.com**.

This notification will be published soon on our Provider Communications web page. Visit this page for on-demand access to current and past communications.

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