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Policy Notice for Our Network Providers

July 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.

Medical Policy Updates

See our online **Document Library** for current medical policies and those with future effective dates, when available. 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 October 1, 2023:

- **Manual or Power Operated Vehicles** (MP9111) — Replaced with new stand-alone policies:
  - **Wheelchairs: Manual and Accessories** (MP9639)
  - **Wheelchairs: Powered and Accessories** (MP9640)
  - **Scooters and Accessories** (MP9641)
- **Dynamic Splinting and Static Progressive Stretch Devices** (MP9289) — Replaced with new policy **Mechanical Stretching Devices for the Treatment of Joint Contractures of the Extremities** (MP9659)

Medical Policies – Prior Authorization Removed

Effective October 1, 2023:

- **Plastic and Reconstructive Surgery** (MP9022)

Procedures and Devices – Medically Necessary for All Indications

Effective July 1, 2023:

- **Non-covered Medical Procedures and Services** (MP9415) — The following are changing to a status of medically necessary, and therefore covered:
  - Piriformis muscle injection
  - Submaximal stress testing to measure cardiorespiratory fitness and all other indications

Effective September 1, 2023:

- **Non-covered Medical Procedures and Services** (MP9415) — The following are changing to a status of medically necessary, and therefore covered:
  - Assistive algorithmic ECG risk based assessment for cardiac dysfunction
  - Corneal hysteresis assessment
  - Interleukin 6 (IL-6)
  - Intra-atrial recording (e.g., AtriAmp™)
  - Laser interstitial thermal therapy (LITT) intracranial
  - Percutaneous arteriovenous fistula creation by tissue approximation using thermal resistance energy (e.g., Ellipsys®) and using magnetic guided arterial and venous catheters and radiofrequency energy (e.g., Wavelin Q™)
  - Quantitative magnetic resonance for the analysis of tissue composition (e.g., LiverMultiscan®) for the diagnosis of liver fibrosis and steatosis related to NAFLD and NASH
  - Subchondroplasty procedure
  - T-Wave alternans

Procedures and Devices – Experimental and Investigational (Non-covered)

Effective September 1, 2023:

- **Non-covered Medical Procedures and Services** (MP9415) — Considered experimental and investigational, and therefore not covered for the following:
  - Percutaneous sacroplasty for osteoporotic sacral insufficiency fractures and all other indications

New Medical Policies

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

Effective October 1, 2023:

- Prior authorization is required for all purchases of manual or power wheelchairs and scooters. Manual or power wheelchairs and scooter accessories, repairs, or modifications with a billed charge of $1,000 or more per item requires prior authorization. Prior authorization is not required for rental and is allowed for 12 months or until 100% of the purchase price has been reached. Rental of medically necessary equipment while the member's own equipment is being repaired does not require prior authorization. Replacement of a wheelchair or scooter with another wheelchair or scooter or a different device requires prior authorization. A back-up manual wheelchair for members with a powered device is considered a duplicate device and/or convenience item and is excluded from coverage. Refer to the Member Certificate or Summary Plan Description for coverage information. See applicable policy for medical necessity criteria and items not eligible for coverage.
  - **Wheelchairs: Manual and Accessories** (MP9639)
  - **Wheelchairs: Powered and Accessories** (MP9640)
  - **Scooters and Accessories** (MP9641)
- Procedures removed from **Plastic and Reconstructive Surgery** (MP9022) — Prior authorization *is required*.
  - **Abdominoplasty/Panniculectomy** (MP9646) — Initial or repeat abdominoplasty/panniculectomy requires prior authorization. Frontal and lateral

photographs are required for panniculectomy. Abdominoplasty is considered medically necessary when documentation indicates how an unrelated or separate abdominal surgery is being performed, how surgical access will be improved, and post-operative healing will be optimized.

  - **Otoplasty** (MP9647) — Photographs are required. Considered medically necessary when documentation indicates surgery is being performed to correct a physical structure or repair the absence of a physical structure.
  - **Rhinoplasty Procedure With or Without Septoplasty** (MP9648) — Considered medically necessary when all of the following criteria are met: member has a nasal deformity with airway obstruction, member has failed medical treatment, and documentation supports medical necessity. Septoplasty as a stand-alone procedure does not require prior authorization.

- Procedures removed from **Plastic and Reconstructive Surgery** (MP9022) — Prior authorization *is not required*.
  - **Scar Revision** (MP9649) — Considered medically necessary when performed to improve or restore normal bodily function or revision is incidental to or follows surgery resulting from injury, sickness, or other disease of the skin.
  - **Liposuction for Lymphedema or Lipedema** (MP9650) — Considered medically necessary when all of the following criteria are met:
    - Procedure is to treat moderate to severe lipedema or moderate to severe lymphedema;
    - Member's condition has not responded to standard conservative treatment;
    - Lipedema or lymphedema causes significant functional impairment which interferes with activities of daily living.

- Prior authorization is not required for the following:
  - **Foot Care** (MP9656) — Considered medically necessary when prescribed by a physician, performed by a healthcare professional, and member has a qualifying condition. Pedicure services by a healthcare professional in the absence of nail disease is not covered. Claims will deny if medically necessary procedure and diagnosis codes do not appear on the claim.
  - **Radiofrequency Ablation (RFA) of Uterine Fibroids** (MP9657) — Laparoscopic RFA for the treatment of uterine fibroids is considered medically necessary. All other forms of RFA for treating uterine fibroids (e.g., transvaginal, transcervical) is considered experimental and investigational, and therefore not covered.
  - **Mechanical Stretching Devices for the Treatment of Joint Contractures of the Extremities** (MP9659) — The following devices are considered experimental and investigational, and therefore not covered: low-load prolonged duration stretch (LLPS), static progressive stretch (SPS) and patient-actuated serial stretching (PASS). Continuous passive motion devices are considered not medically necessary.
  - **Photodynamic Therapy with Visudyne® (verteprofin) for Ocular Indications** (MP9660) — Prior authorization is not required for Verteporfin (Visudyne®) photodynamic therapy using a non-thermal laser, Considered medically necessary for the treatment of subfoveal choroidal neovascularization (predominantly classic, minimally classic, or occult) when associated with any of the following: wet age-related macular degeneration, pathologic myopia, presumed ocular histoplasmosis syndrome, central serous chorioretinopathy, polypoidal choroidal vasculopathy, and choroidal hemangioma.

Medical Policy Revisions

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

Effective June 1, 2023:

- **Cardioverter-Defibrillator, Wearable (ZOLL LifeVest®)** (MP9522) — Automatic external defibrillator may be considered medically necessary when documentation supports a wearable cardioverter-defibrillator is not an appropriate device for the member (e.g., pediatric member or anatomic changes preclude use of vest).

Effective July 1, 2023:

- **Treatment of Obstructive Sleep Apnea (OSA) and Related Conditions with Invasive Treatments and Surgery** (MP9585) — Tongue-based suspension surgery is considered experimental and investigational, and therefore not covered for all indications.

Effective September 1, 2023:

- **Surgical and Minimally Invasive Treatments for Benign Prostatic Hypertrophy/ Hyperplasia (BPH)** (MP9361) — Considered medically necessary for members with documented urinary outflow obstruction secondary to BPH (not an all-inclusive list): fiber laser enucleation technologies (e.g., HoLAP, HoLEP, HoLRP); thulium laser (ThuLEP); transurethral vaporization of the prostate (TUVP) therapies, including contact laser vaporization, electrovaporization, and photoselective vaporization; waterjet tissue ablation (AquaBeam® Robotic System). Prior authorization is not required. Transrectal microwave hyperthermia (TRMT) and transuretheral ultrasound laser-induced prostatectomy (TULIP) are considered experimental and investigational, and therefore not covered.

Effective October 1, 2023:

- **Plastic and Reconstructive Surgery** (MP9022) — The following plastic surgery procedures do not require prior authorization: congenital nevus, congenital ear tags, Bell's Palsy if sling is necessary to lift facial muscles, removal of lesions or warts, surgery to correct mid-face retrusion or hemifacial microsomnia, and breast reconstruction for congenital anomalies.
- **Total Ankle Replacement** (MP9363) — Considered medically necessary as an alternative to ankle arthrodesis when all of the following criteria are met: moderate or severe pain related to osteoarthritis; post traumatic arthritis or rheumatoid arthritis; failed conservative treatment; no contraindications; and U.S. Food and Drug Administration (FDA)-approved device is used. Prior authorization is not required.
- **Transcranial Magnetic Stimulation (TMS)** (MP9526) — TMS requires prior authorization and is considered medically necessary for members 18 years of age or older who have a confirmed diagnosis of major depressive disorder, single or recurrent episode, and the following criteria are met:
  - Resistant to treatment with psychopharmacological agents as evidenced by lack of clinically significant response to two trials of psychopharmacologic agents in the current depressive episode from at least two different agent classes. At least one of the treatment trials must be administered at an adequate course of mono- or poly-drug therapy.
  - Inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from at least two different classes, with distinct side effects. Pyschopharmacologic agent distinct side effect will be considered intolerable

when those side effects are of a nature where they are not expected to diminish or resolve with continued administration of the drug.

Accelerate TMS protocols and/or Theta burst stimulation protocols are considered experimental and investigational, and therefore not covered.

- **Actigraphy** (MP9559) — Considered experimental and investigational, and therefore not covered as a stand-alone test for the diagnosis and monitoring of obstructive sleep apnea/hypopnea syndrome.

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 **DHPPharmacyServices@deancare.com**.

Pharmacy Drug Formulary Maintenance

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

- **Alendronate** 70 mg/75 mL oral solution — Moved to non-preferred brand tier.
- **Atomoxetine** (Strattera equivalent) 10, 18, 25, 40, 60, 80, & 100 mg capsules — Moved to preferred generic tier.
- **Cortrophin (corticotropin)** 80 units/mL gel — Moved to not covered.
- **sulfacetamide acne formulations**
  - **Ovace Plus Gel** — Moved to not covered.
  - **Ovace Plus Shampoo** — Moved to not covered.
  - **Rosula Wash** — Removed from formulary as no longer available.
  - **sodium sulfacetamide gel** — Moved to not covered.
  - **sodium sulfacetamide shampoo** — Moved to not covered.
  - **sodium sulfacetamide/sulfur wash** — Moved to not covered.
  - **Sumaxin Wash** — Moved to not covered.
- **teriparatide** (Forteo equivalent) 620 mcg/2.48 mL pen:
  - **Forteo** — Moved to not covered.
  - **teriparatide** — Moved to preferred brand/specialty tier and mandatory specialty pharmacy.
  - **Tymlos** — No change; staying as preferred brand/specialty tier and mandatory specialty pharmacy.

Pharmacy Drug New or Expanded Formulations

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

- **Amjevita (adalimumab-atto)** 10 mg/0.2 mL syringe — Moved to not covered.
- **Kalydeco (ivacaftor)** 13.4 mg packet — Moved to preferred brand/specialty tier, with prior authorization required, quantity limit (2 packs per day), split fill and limited distribution.
- **Liqrev (sildenafil)** 10 mg/mL oral suspension — Moved to not covered.
- **Udenyca (pegfilgrastim)** 6 mg autoinjector — Moved to not covered.
- **Zolpidem** 7.5 mg capsule — Moved to not covered.

Pharmacy Drug New Indications

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

- **Rinvoq (upadacitinib)** 15, 30, & 45 mg tablets — Added indication approved for the treatment of moderately to severely active Crohn's disease in patients who have had inadequate response or intolerance to 1 or more tumor necrosis factor (TNF) blockers.

Pharmacy Prior Authorization Form Updates

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

- **Cimzia (certolizumab pegol)** — Updated step-through criteria for Crohn's disease indication: The current trial of adalimumab will be expanded to include a trial of 2 preferred products—including adalimumab, Rinvoq (upadacitinib), Stelara (ustekinumab) or Skyrizi (risankizumab)—that are currently approved for treatment of Crohn's disease.
- **Diacomit (stiripentol)** — Initial criteria will be updated to include "or in consultation with" to provider criterion.
- **Epidiolex (cannabidiol)** — Initial criteria will be updated to include "in consultation with" to provider criterion and continuation criteria will require attestation of a meaningful reduction in seizure frequency and/or severity.
- **Extended products update:**
  - **Qbrexza (glycopyrronium)** — Retained trial/failure of alternatives, changed approval duration to lifetime eligibility, and removed specialist requirement.
  - **Winlevi (clascoterone)** — Retained trial/failure of alternatives and changed approval duration to lifetime eligibility.
  - **Fetzima (levomilnacipran)** — Retained trial/failure of alternatives and changed approval duration to lifetime eligibility.
- **Lumakras (sotorasib)** — Added criterion: Patient has not experienced disease progression with previous KRAS G12C inhibitor.
- **Xgeva (denosumab)** — Added specialist prescriber requirement to hypercalcemia of malignancy indication and removed IV bisphosphonate step.

New Medical Benefit Drug Policies

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

- **Elfabrio (pegunigalsidase-alfa-iwxj)** — New medical policy and prior authorization is required.
- **Omisirge (omidubicel-onlv)** — New medical policy and prior authorization is required.
- **Qalsody (tofersen)** — New medical policy and prior authorization is required.
- **Self-Administrated Drug Policy 2023** — New pharmacy benefit reimbursement guideline policy.

Changes to Medical Benefit Drug Policies

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

- **Hemgenix (etranacogene dezaparovec-drlb)** — Criteria language updated.

Effective for dates of service on and after July 28, 2023:

- **Oncology policies with Magellan Rx** — The medical benefit drug policy documents for the drugs listed below will be updated and accessible via the "Medical Oncology Drugs" link on our Health Medical Management web page:
  - **Adcetris (brentuximab vedotin)**
  - **Anti-Inhibitor_Ab**

- **Anti-Inhibitor_Complex**
- **Bavencio (avelumab)**
- **bevacizumab (Avastin, Mvasi, Zirabev, Alymsys, Vegzelma)**
- **Coagulation Factor XIII A subunit Tretten**
- **Cyramza (ramucirumab)**
- **Enhertu (fam-trastuzumab deruxtecan-nxk)**
- **Erbitux (cetuximab)**
- **Gazyva (obinutuzumab)**
- **Hemophilia Products Factor VIIa (NovoSeven RT, Sevenfact)**
- **Hemophilia Products Factor VIII (Advate, Adynovate, Afstyla, Eloctate)**
- **Hemophilia Products Factor VIII VWF Complex (Alphanate, Humate P, Wilate)**
- **Hemophilia Products Factor IX (AlphaNine SD, Alprolix, BeneFIX, Idelvion, Ixinity, Mononine)**
- **Hemophilia Products Factor X (Coagadex)**
- **Hemophilia Products Factor XIII (Corifact)**
- **Hemophilia Products von Willebrand Factor (Vonvendi)**
- **Imfinzi (durvalumab)**
- **Imjudo (tremelimumab-actl)**
- **Jemperli (dostarlimab-gxly)**
- **Kyprolis (carfilzimib)**
- **Libtayo (cemiplimab-rwlc)**
- **Opdivo (nivolumab)**
- **Paclitaxel Albumin-Bound**
- **Perjeta (pertuzumab)**
- **Rituximab IV**
- **Ryplazim (plasminogen, human-tvmh)**
- **Spravato (esketamine)**
- **Tecentriq (atezolizumab)**
- **Trastuzumab IV**
- **Vectibix (panitumumab)**
- **Yervoy (ipilimumab)**
- **Yondelis (trabectedin)**

Providers are encouraged to refer to **the Magellan Rx website** for a complete list of co-branded policies starting on July 1, 2023. In addition to co-branding and reformatting, some policies will also be revised for new criteria effective October 1, 2023. Providers should review drug policies for any changes to authorization criteria and/or length of authorization that may impact 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 WellFirst Health 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 WellFirst Health Document Library is directly accessible at **wellfirstbenefits.com/document-library** or by visiting **wellfirstbenefits.com** and following the step-by-step instructions below:

- Select **Providers,** and then **Medical Management**.
- Under WellFirst Health 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 (MRx) 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.