



Payment Policy & Coding Monthly Policy Updates

Effective October 15, 2026 (unless otherwise noted)

Note – Log-in is needed for policy update sections marked with an asterisk *. Use this link to log-in, [Cigna for Health Care Professionals](#) > Resources > Reimbursement and Payment Policies.

Medical Coverage Policy	New, Updated, or Retired?	Comments
Airway Clearance Devices in the Ambulatory Setting - (0069)	Updated	Important change in coverage criteria/policy: Expanded coverage for high-frequency chest wall compression device to include immotile cilia syndrome.
Atrial Fibrillation: Nonpharmacological Treatments – (0469)	Updated	Posted 10/15/2026, Effective 1/15/2027 Important changes in coverage criteria/policy: - Title change from: "Atrial Fibrillation: Nonpharmacological Treatments" to "Left Atrial Appendage Closure or Exclusion" - Moved policy statements unrelated to LAA closure or exclusion procedures to CP 0532 Cardiac Electrophysiological (EP) Studies and Cardiac Ablation of Abnormal Electrical Rhythms - Revised headers and formatting changes to improve clarity

		4. Revised the policy statement regarding stand-alone surgical left atrial appendage (LAA) exclusion/excision to improve readability and clarity by correcting grammar.
Bone Graft Substitutes - (0118)	Updated	Posted 10/1/2026, Effective 10/1/2026 Important changes in coverage criteria/policy: 1. Addition of the standard benefit coverage language regarding the use of bone graft materials in conjunction with dental implants and removal of benefit related statements from the policy criteria 2. Revision of experimental, investigation, unproven policy statement for bone graft materials and/or substitutes to now include the description for newly effective CPT code 1095T
Cardiac Electrophysiological (EP) Studies - (0532)	Updated	Posted 10/15/2026, Effective 1/15/2027 Important changes in coverage criteria/policy: 1. Title change from: "Cardiac Electrophysiological (EP) Studies" to "Cardiac Electrophysiological (EP) Studies and Cardiac Ablation of Abnormal Electrical Rhythms" 2. Consolidated content from CP 0529 (Cardiac Ablation of Abnormal Electrical Rhythms) and CP 0469 (Atrial Fibrillation: Nonpharmacological Treatments) into CP 0532 Cardiac Electrophysiological (EP) Studies 3. Revised policy statement for "guideline directed medical therapy" (GDMT) in criteria 1.b.iii by removing and replacing with the exact pharmacologic agents 4. Revised policy statement for adult congenital heart disease criterion 1.d.ii language to focus on risk stratification for ICD candidacy in individuals with repaired moderate or severe complexity (terms defined in overview section) adult congenital heart disease and unexplained syncope, and removed references to 'moderate ventricular dysfunction' and 'marked hypertrophy'. 5. Added policy statement to clarify that left atrial pacing and recording (CPT® 93621) and left ventricular pacing and recording (CPT® 93622) are considered medically necessary when performed as add-on components of a medically necessary diagnostic electrophysiological study (CPT® 93619 or 93620) and supported by the clinical documentation (1.m.). 6. Added policy statement for coverage of additional catheter ablation of a separate and distinct arrhythmogenic mechanism when a newly identified spontaneous or induced

		arrhythmia requiring ablation is identified during a medically necessary ablation procedure. This criterion is repeated in the ablation sections for afib (criterion 5), SVT (criterion 7), and abnormal ventricular electrical rhythms (criterion 9). 7. Added policy statement for when a separate and distinct arrhythmogenic mechanism is NOT found, an additional ablation is considered NOT medically necessary (criterion 11). 8. Revised policy statement for standalone surgical Maze or modified Maze procedure (criterion 15) from experimental, investigational, or unproven to not medically necessary due to no longer meeting Cigna's definition of EIU.
Diabetes Equipment and Supplies – (0106)	Updated	Minor change in coverage Added policy statement for Simplera Sync to non-therapeutic/adjunctive continuous glucose monitoring system (CGMS) coverage statement
Infertility Services – (0089)	Updated	Posted 07/15/2026, Effective 10/15/2026 Important changes in coverage criteria/policy: - Revised policy statement regarding evaluation of the female factor to include sonosalpingography/hysterosalpingo-contrast sonography (HyCoSy), or hysterosalpingo-foam sonography (HyFoSy) and remove clomiphene challenge test. - Revised policy statement regarding female infertility treatment services to remove ovarian wedge resection, tubal embryo transfer (TET), low tubal ovum transfer (LTOT), and pronuclear stage transfer (PROST). - Revised policy statement regarding intracytoplasmic sperm injection (ICSI) and associated services. - Revised policy statement regarding pharmacologic treatment of endocrinopathies for male infertility to remove pulsatile gonadotropin-releasing hormone and androgens - Revised policy statement regarding male infertility treatment services to remove seminal tract washout. - Revised policy statement regarding cryopreservation, storage and thawing to combine mature oocytes or supernumerary embryos generated during a covered assisted reproductive technology cycle. - Revised policy statement regarding cryopreservation, storage and thawing to include sperm obtained through surgical retrieval techniques (e.g., testicular or epididymal sperm retrieval) when ejaculatory sperm are not available.

		- Revised policy statement regarding cryopreservation, storage and thawing to include mature gametes (oocytes or sperm) or embryos for individuals facing anticipated infertility due to chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or surgical removal of reproductive organs for treatment of disease. - Added a policy statement for mature gametes (oocytes or sperm) or embryos for fertility preservation associated with age-related reproductive decline in otherwise healthy individuals. - Removed policy statements regarding cryopreservation services: embryos when not undergoing covered active infertility treatment; sperm; and oocytes for any indication other than listed above. - Revised policy statement regarding assisted embryo hatching - Added a policy statement regarding sperm DNA integrity testing (e.g., sperm DNA fragmentation testing, TUNEL assay, Comet assay, sperm chromatin structure assay [SCSA]) - Revised policy statement of experimental/investigational/unproven services to remove direct intraperitoneal insemination, intrafollicular insemination, fallopian tube sperm transfusion, laser-assisted necrotic blastomere removal from cryopreserved embryos, SmartJane™ screening test [Biome, Inc], and saline-air infused sono-hysterosalpingogram (e.g., femVue® [Femasys, Inc.]).
Laboratory Testing Services - (0604)	Updated	Effective 10/1/2026 Minor change in coverage criteria/policy: Revised not covered or reimbursable section.
Molecular and Proteomic Diagnostic Testing for Hematology and Oncology Indications – (0520)	Updated	Effective 10/1/2026 Minor change in coverage criteria/policy: Revised not covered or reimbursable section.
Orthognathic Surgery – (0209)	Updated	Minor changes in coverage criteria/policy: - Revised policy statement for orthognathic surgery: - Added minor clarifications in facial skeletal deformities criteria - Incorporated documentation requirements - Removed policy statement regarding services considered integral to orthognathic surgery.

Preventive Care Services – (A004)	Updated	Effective 10/1/2026 Minor change in coverage criteria/policy: Added ICD-10 code N64.89 (Other specified disorders of breast) to diagnosis codes appropriate for average risk breast cancer screening.
Tissue-Engineered Skin Substitutes – (0068)	Updated	Effective 10/1/2026 Minor change(s) in coverage criteria/policy: Added the following products to EIU policy statement: Amchomatrix, Dermabind SL optic, and Puraply MZ
Treatment of Cutaneous and Vascular Lesions – (0313)	Updated	Posted 7/15/2026, Effective 10/15/2026 Important change in coverage criteria/policy: Added policy statement for intense pulsed light (IPL)
Autologous Platelet-Derived Growth Factors (Platelet-Rich Plasma [PRP]) – (0507)	Updated	No change in coverage.
Heart, Lung, and Heart-Lung Transplantation – (0129)	Updated	No change in coverage
Kidney Transplantation, Pancreas-Kidney Transplantation, and Pancreas Transplantation Alone – (0146)	Updated	No change in coverage
Lymphedema and Lipedema Surgical Treatments – (0531)	Updated	Effective date 10/1/2026 No change in coverage

Metatarsophalangeal Joint Replacement – (0486)	Updated	No change in coverage.
Mucosal Integrity Testing – (0577)	Updated	No change in coverage.
Nucleic Acid Pathogen Testing (0530)	Updated	No change in coverage.
Radiofrequency Ablation (RFA) Thyroid Nodules – (0575)	Updated	No change in coverage.
Radiofrequency Therapy for Fecal Incontinence (0576)	Updated	No change in coverage.
Sacral Nerve Stimulation for Urinary Voiding Dysfunction, Fecal Incontinence and Constipation – (0404)	Updated	No change in coverage.
Subtalar Joint Implantation (Subtalar Arthroereisis) – (0486)	Updated	No change in coverage.
Rosacea Procedures – (0482)	Retired	Effective 10/15/2026 Content addressed in policies 0313 Treatment of Cutaneous and Vascular Lesions and 0505 Excimer Laser, Dermabrasion and Chemical Peels for Dermatologic Conditions.
ASH Guidelines	New, Updated, or Retired?	Comments
		No updates for October 2026

eviCore Guidelines	New, Updated, or Retired?	Comments
Cobranded Cigna-EviCore Gastrointestinal Endoscopic Procedure Guidelines	Updated	Effective 11/5/2026 One guideline was updated with no clinically impactful changes: • Esophagogastroduodenoscopy (EGD)
Cobranded Cigna-EviCore High-Tech Imaging and Cardiology Guidelines	Updated	Effective 11/5/2026 One guideline was updated with a clinical change that will expand coverage: • Spine Imaging One guideline was updated with clinical changes that will expand and limit coverage: • Oncology Imaging Effective 2/2/2027 7 guidelines were updated with clinical changes that will expand coverage: • Musculoskeletal Imaging • Pediatric Abdomen Imaging • Pediatric Musculoskeletal Imaging • Pediatric Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging • Pelvis Imaging • Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging • Preface to the Imaging Guidelines 3 guidelines were updated with clinical changes that will expand and limit coverage: • Chest Imaging • Head Imaging • Peripheral Vascular Disease (PVD) Imaging One guideline was updated with clinical changes that will limit coverage: • Pediatric Pelvis Imaging

		5 guidelines were updated with no clinical changes: • Pediatric and Special Populations Spine Imaging • Pediatric Chest Imaging • Pediatric Head Imaging • Pediatric Neck Imaging Pediatric Peripheral Vascular Disease (PVD) Imaging
Cobranded Cigna-EviCore Lab Management Guidelines	Updated	Effective 10/1/2026 Important changes in coverage criteria: • The following sections were updated to add new 10/1/2026 CPT codes: ◦ Decipher Prostate Genomic Classifier ◦ Experimental, Investigational, or Unproven Laboratory Testing ◦ Hereditary Cancer Syndrome Genetic Testing ◦ Human Platelet and Red Blood Cell Antigen Genotyping ◦ Somatic Mutation Testing Effective 1/1/2027 Important changes in coverage criteria: • 3 new guidelines were added: ◦ Exome and Genome Sequencing ◦ Heath Equity Considerations ◦ Inherited Retinal Disorder Genetic Testing • 2 guidelines were retired: ◦ Exome Sequencing ◦ Genome Sequencing • 16 guidelines underwent substantive updates to criteria: ◦ Special Circumstances Influencing Coverage Determinations ◦ Laboratory Billing and Reimbursement ◦ Genetic Testing to Predict Disease Risk ◦ Experimental, Investigational, or Unproven Laboratory Testing ◦ Pharmacogenomic Testing for Drug Toxicity and Response ◦ Charcot-Marie-Tooth Neuropathy Genetic Testing ◦ Chromosomal Microarray Testing For Developmental Disorders (Prenatal and Postnatal) ◦ HFE Hemochromatosis Genetic Testing

		○ PTEN Hamartoma Tumor Syndromes Genetic Testing ○ Somatic Mutation Testing ○ Epilepsy Genetic Testing ○ Mitochondrial Disorders Genetic Testing ○ Hereditary Pancreatitis Genetic Testing ○ Decipher Prostate Cancer Classifier ○ Human Platelet and Red Blood Cell Antigen Genotyping ○ Hereditary Connective Tissue and Thoracic Aortic Disease Genetic Testing ○ Remaining guidelines had no substantive changes to criteria.
Cobranded Cigna-EviCore Peripheral Vascular Intervention Guidelines	Updated/ New	Effective 11/5/2026 Guidelines were updated with several clinical changes that will expand and limit coverage. Effective 2/1/2027 New guideline: • IJV Decompression in Eagle Syndrome
Cobranded Cigna-EviCore Radiation Oncology Clinical Guidelines	Updated	Effective 11/5/2026 Guidelines were updated with clinically impactful changes as follows: One new guideline: • Iodine-131 (I-131) Nine guidelines include clinical changes that will expand coverage: • Bladder Cancer • Breast Cancer • Endometrial Cancer • Gastric Cancer • Kidney Cancer • Non-Small Cell Lung Cancer • Rectal Cancer • Selective Internal Radiation Therapy (SIRT)

		• Small Cell Lung Cancer Twelve guidelines include clinical changes that will expand and limit coverage: • Adrenocortical Carcinoma • Esophageal Cancer • Hepatobiliary Cancer • Image-Guided Radiation Therapy (IGRT) • Non-Malignant Disorders • Pancreatic Cancer • Skin Cancer – Melanoma • Skin Cancer – Non-Melanoma • Soft Tissue Sarcomas • Thymoma and Thymic Cancer • Urethral Cancer and Cancers of the Ureter and Renal Pelvis • Vulvar Cancer Two guidelines include clinical changes that will limit coverage: • Multiple Myeloma and Solitary Plasmacytomas • Non-Hodgkin Lymphoma
Cobranded Cigna-EviCore Sleep Disordered Breathing Diagnosis and Treatment Guidelines	Updated	Effective 11/5/2026 Guidelines were updated with several clinical changes that will expand and limit coverage.
Administrative Policy	New, Updated, or Retired?	Comments
Custodial and Non-Skilled Services - (A012)	Updated	Effective 9/15/2026 • No changes.

Authorized Generics (A008)	Updated	Effective 10/15/2026 Removed criteria for Mitigare, Tresiba, Triglide from the policy.
Cigna Healthcare Drug Coverage Policy	New, Updated, or Retired?	Comments
Alpha1 – Proteinase Inhibitor Products (IP0387)	Update	Effective 10/15/2026 No criteria changes.
Amyloidosis – Wainua (IP0628)	Updated	Effective 10/1/2026 Preferred Product Table. Employer Plans Clarified the current requirements for Value, Advantage, Total Savings apply to the autoinjector. Added new preferred product requirements for Wainua prefilled syringes. Coding Information Added HCPCS C9311 Updated the description for C9399, J3490 to include the note "Code effective until 09/30/2026"
Antibiotics – Xifaxan Drug Quantity Management Policy – Per Days (DQM041)	New	Effective 10/1/2026 New policy. Current Xifaxan quantity limitation criteria, found in CP 120 (Quantity Limitations), moved into this new policy.
Antifungals-Vivjoa (IP0513)	Updated	Effective 10/15/2026 Policy Title: Updated from "Oteseconazole" to "Antifungals – Vivjoa" Recurrent Vulvovaginal Candidiasis Updated from "Not of reproductive potential (persons who are postmenopausal or have another reason for permanent infertility such as tubal ligation, hysterectomy, salpingo-oophorectomy)" to "Patient is not of reproductive potential Note: A person who is NOT of

		reproductive potential is defined as a person who is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)." Updated from "Not lactating (for example, breastfeeding)" to "Patient is NOT breastfeeding." Added preferred product requirements for Employer Plans and Individual and Family Plans.
Attention Deficit Hyperactivity Disorder Non-Stimulant Medications (IP0217)	Updated	Effective 10/1/2026 Atoncy: Atoncy (atomoxetine oral solution) and authorized generic were added to the policy. Employer Group Plans Added preferred product requirements for Atoncy and the authorized generic. Individual and Family Plans Added preferred product requirements for Atoncy and the authorized generic. Pervasive Developmental Disorders (e.g., autism spectrum disorder, Asperger's disorder): This Other Use with Supportive Evidence was removed from the policy.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Medications for Employer Group Plans (IP0477)	Updated	Effective 10/1/2026 Idiopathic Hypersomnia: The approval condition was changed to as listed; previously it was worded "Idiopathic Hypersomnolence". Additionally, the previous requirement that diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i.e., sleep center) was removed and was replaced with the following three requirements: A) patient has been evaluated using polysomnography and a multiple sleep latency test; B) according to the prescriber, results of the polysomnography and a multiple sleep latency test are congruent with a diagnosis of idiopathic hypersomnia; and C) the medication has been prescribed by or in consultation with a sleep specialist or a neurologist. Conditions Not Recommended for Approval: The condition not recommended for approval "Long-Term Combination Therapy (i.e., > 2 months) with an Atomoxetine Product" was revised to as listed; previously it stated "atomoxetine (Strattera, generic)" instead of "an atomoxetine product". Effective 10/15/2026 Methylphenidate ER ODT: This product (authorized generic to Cotempla-XR ODT) rolled into the policy.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Medications for	Updated	Effective 10/1/2026 Idiopathic Hypersomnia: The approval condition was changed to as listed; previously it was worded "Idiopathic Hypersomnolence". Additionally, the previous requirement that diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i.e., sleep center) was removed and was replaced with the following three

Individual and Family Plans (IP0584)		requirements: A) patient has been evaluated using polysomnography and a multiple sleep latency test; B) according to the prescriber, results of the polysomnography and a multiple sleep latency test are congruent with a diagnosis of idiopathic hypersomnia; and C) the medication has been prescribed by or in consultation with a sleep specialist or a neurologist. Conditions Not Recommended for Approval: The condition not recommended for approval "Long-Term Combination Therapy (i.e., > 2 months) with an Atomoxetine Product" was revised to as listed; previously it stated "atomoxetine (Strattera, generic)" instead of "an atomoxetine product". Effective 10/15/2026 Methylphenidate ER ODT: This product (authorized generic to Cotempla-XR ODT) rolled into the policy.
Cardiology – Ivabradine (IP0286)	Updated	Effective 10/15/2026 Employer Plans Preferred Product Table: Updated preferred product for Corlanor solution from "Patient has tried the bioequivalent generic product, ivabradine solution, AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which would result, per the prescriber, in a significant allergy or serious adverse reaction" to "Patient meets ONE of the following (1 or 2): 1. Patient has tried and cannot take generic ivabradine tablets; OR 2. Patient cannot swallow or has difficulty swallowing tablets."
Cardiology – Lodoco (IP0595)	Updated	Effective 10/15/2026 No criteria changes.
Complement Inhibitors – Fabhalta (IP0614)	Updated	Effective 10/1/2026 Primary Immunoglobulin A Nephropathy: <u>Initial Therapy</u>: The option that the patient has a urine protein-to-creatinine ratio ≥ 1.5 g/g was modified to a urine protein-to-creatinine ratio ≥ 0.5 g/g.
Complement Inhibitors – Veopoz (IP0587)	Updated	Effective 10/15/2026 No criteria changes.
Dermatology – Opzelura - (IP0369)	Updated	Effective 10/15/2026

		Atopic Dermatitis: Added a criterion allowing an exception to the requirement for a trial of a prescription topical corticosteroid for a patient treating atopic dermatitis affecting the face, eyes/eyelids, skin folds, and/or genitalia. Vitiligo: Added a criterion allowing an exception to the requirement for a trial of a prescription topical corticosteroid for a patient treating vitiligo affecting the face, eyes/eyelids, skin folds, and/or genitalia. Appendix: Updated to add Exdensur (depemokimab-ulaa SC injection) and Anzupgo (delgocitinib cream). Otezla (apremilast tablets), Sotyktu (deucravacitinib tablets), Zeposia (ozanimod capsules), and Velsipity (etrasimod tablet) were removed. Generic products were also added for Xeljanz and Xeljanz XR.
Dermatology – Zoryve Drug Quantity Management Policy – Per Days - (DQM042)	New	Effective 10/15/2026 New policy. Criteria was previously located in the <i>Quantity Limitations – (1201)</i> policy.
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	Effective 10/1/2026 Added preferred product requirement criteria for the following: EFFECTIVE 10/1/2026: glipizide 15 mg tablets, Quiofic, folic acid oral solution, Bysanti tablets and titration pack, Xenleta, Hemady, and Antivert 50 mg tablets EFFECTIVE 10/15/2026: Dexlyt and Nereus Updated preferred product requirement criteria for the following: EFFECTIVE 10/1/2026: Bucapsol capsules, Lybalvi, Fanapt, Cobenfy, Glucagon Emergency Kit, Gvoke HypoPen Auto-Injector, Kit, or Prefilled Syringe, Zegalogue, lactulose 10 gram packet, Flector Patch (brand), Licart, Zoryve 0.3% cream, and meclizine 50 mg tablets Removed preferred product requirement criteria for the following: EFFECTIVE 10/1/2026: Tekturna HCT, Gelnique 10% gel, Vesicare LS, sertraline 150 and 200 mg capsules, fluticasone propionate HFA 44 mcg, Pentasa 250 mg capsules
Enzyme Replacement Therapy – Avlayah - (IP0807)	Updated	Effective 10/1/2026 Coding Information Added HCPCS J1757 Updated the description for J3590 to include the note "Code effective until 09/30/2026"

Enzyme Replacement Therapy – Loargys – (IP0798)	Updated	Effective 10/1/2026 Coding Information Added HCPCS J1818 Updated the description for J3590 to include the note "Code effective until 09/30/2026"
Enzyme Replacement Therapy – Sucraid (IP0447)	Updated	Effective 10/1/2026 Congenital Sucrase-Isomaltase Deficiency. Documentation requirements were added to the following criteria: The diagnosis is established by ONE of the following: Patient had a biopsy of the small bowel with disaccharidase levels consistent with congenital sucrose-isomaltase deficiency; OR Patient has a molecular genetic test demonstrating homozygous or compound heterozygous pathogenic or likely pathogenic sucrase-isomaltase gene variant; OR Patient had a breath test with results consistent with congenital sucrase-isomaltase deficiency.
Glycogen Storage Disorder – Gene Therapy – Genglycos (IP0845)	New	Effective 10/8/2026 New policy.
Graft-Versus-Host Disease – Tregzi (IP0821)	New	Effective 10/1/2026 New policy.
Hematology – Gene Therapy – Casgevy (IP0615)	Updated	Effective 10/15/2026 Sickle Cell Disease: The following changes were made: 1. For the requirement regarding Human Leukocyte Antigen (HLA)-matched donor, the word "related" was added; it now reads: Human Leukocyte Antigen (HLA)-matched related donor. 2. Regarding the Note of examples of severe vaso-occlusive crises or events for the criterion that patient had at least four events in the previous 2 years, "An episode of dactylitis (in a patient < 5 years of age" was added). And the fever temperature for acute chest syndrome was changed from 99.5°F to 101.3°F. 3. For the requirement that lists conditions that the patients does not have, a new condition was added: "History of abnormal transcranial doppler, if the patient is < 18 years of age".

		4. For the requirement that busulfan is used for myeloablative conditioning, a Note that pharmacokinetically guided busulfan dosing is recommended for myeloablative conditioning was added. 5. For the requirement regarding sickle hemoglobin level and total hemoglobin level, the word "goal" is added and the timepoints were deleted. The new requirements read: Sickle hemoglobin level goal is < 30% of total hemoglobin and total hemoglobin level goal is ≤ 11 g/dL. 6. For the requirement regarding reproductive potential, an option that according to the prescribing physician, the patient is <u>not</u> of reproductive potential was added. The requirements for females and males of reproductive potentiation remain unchanged. Transfusion-Dependent Beta-Thalassemia: The following changes were made: 1. For the requirements regarding Human Leukocyte Antigen (HLA)-matched donors, the word "related" was added; it now reads: Human Leukocyte Antigen (HLA)-matched related donor. 2. For the requirement regarding severe iron overload, the Note, specifically regarding high liver iron concentration, was revised as written. Previously it read: high liver iron concentration (≥ 15 mg/g). 3. For the requirement that busulfan is used for myeloablative conditioning, a Note that pharmacokinetically guided busulfan dosing is recommended for myeloablative conditioning was added. 4. For the requirement regarding total hemoglobin level, the word "goal" was added, and the timepoints were deleted. The new requirement reads: Total hemoglobin level goal is ≤ 11 g/dL. 5. For the requirement regarding reproductive potential, an option that according to the prescribing physician, the patient is not of reproductive potential was added. The requirements for females and males of reproductive potentiation remain unchanged, 6. A new requirement that patient does not have "associated alpha-thalassemia and more than one alpha deletion or alpha multiplication or sickle cell beta-thalassemia variant" was added.
Hematology – Omisirge - (IP0817)	Updated	Effective 10/1/2026 Coding Information Added HCPCS J3406 Updated the description for C9399 J3490 & J3590 to include the note "Code effective until 09/30/2026"

Hematology – Plerixafor (IP0139)	Updated	Effective 10/15/2026 No criteria changes.
Hepatitis C – Harvoni Prior Authorization Policy (IP0735)	Updated	Effective 10/01/2026 No criteria changes.
Hepatitis C – Vosevi Prior Authorization Policy - (IP0736)	Updated	Effective 10/15/2026 Chronic Hepatitis C Virus (HCV) Genotype 1b, 2, 4, 5, or 6. The Note with examples of NS5A-containing regimens was updated to include Epclusa (sofosbuvir/velpatasvir) generic tablets and Harvoni (ledipasvir/sofosbuvir) generic tablets. Chronic Hepatitis C Virus (HCV), Genotype 1a or 3. The Note with examples of NS5A-containing regimens was updated to include Epclusa (sofosbuvir/velpatasvir) generic tablets and Harvoni (ledipasvir/sofosbuvir) generic tablets. Conditions Not Covered Hepatitis C Virus (HCV) [any genotype], Combination with Any Other Direct-Acting Antivirals (DAAs) [Not Including Ribavirin]: “Not including ribavirin” was added to this Condition Not Covered.
Immune Disorders – Gene Therapy – Kresladi (IP0846)	New	Effective 10/15/2026 New policy.
Immunologicals – Ebglyss (IP0708)	Updated	Effective 10/15/2026 No criteria changes.
Immunologicals – Ebglyss Drug Quantity Management Policy – Per Days (DQM030)	Updated	Effective 10/15/2026 No criteria changes.
Inflammatory Conditions – Adalimumab Products Drug Quantity Management Policy – Per Days - (DQM005)	Updated	Effective 10/15/2026 Humira (adalimumab SC injection) CD, UC, or HS Starter Pack 6 x 40 mg/0.8 mL pens: Product was removed from the policy (obsolete for more than 3 years). Humira (adalimumab SC injection) Psoriasis, Uveitis, or Adolescent HS Starter Pack 4 x 40 mg/0.8 mL pens: Product was removed from the policy (obsolete for more than 3 years).

Inflammatory Conditions – Entyvio Subcutaneous DQM Policy – Per Days – (DQM006)	Updated	Effective 10/15/2026 No criteria changes.
Inflammatory Conditions – Etanercept Products Prior Authorization Policy – (IP0673)	Updated	Effective 10/15/2026 No criteria changes.
Inflammatory Conditions – Kineret Drug Quantity Management Policy – Per Days - (DQM008)	Updated	Effective 10/01/2026 No criteria changes.
Inflammatory Conditions – Legselvi Prior Authorization Policy - (IP0751)	Updated	Effective 10/1/2026 No criteria changes.
Inflammatory Conditions – Taltz Drug Quantity Management Policy – Per Days - (DQM040)	Updated	Effective 10/15/2026 No criteria changes.
Inflammatory Conditions – Tocilizumab Intravenous Products Preferred Specialty Management Policy – (PSM012)	Updated	Effective 10/15/2026 No criteria changes.

Inflammatory Conditions – Tofacitinib Products Prior Authorization Policy – (IP0692)	Updated	Effective 10/15/2026 No criteria changes.
Inflammatory Conditions – Ustekinumab Intravenous Products Prior Authorization Policy – (IP0686)	Updated	Effective 10/01/2026 Ulcerative Colitis: The age requirement was modified from ≥ 18 years to ≥ 2 years of age. Dosing was updated to add an option for a patient weighing ≥ 10 kg but ≤ 25 kg. In a patient weighing ≤ 55 kg, specified the lower limit of weight as > 25 kg.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Prior Authorization Policy (IP0687)	Updated	Effective 10/01/2026 Ulcerative Colitis: The age requirement was modified from ≥ 18 years to ≥ 2 years of age. Leukocyte Adhesion Deficiency-I. This new indication was added under Other Uses with Supportive Evidence.
Inflammatory Conditions – Zymfentra DQM Policy – Per Days – (DQM007)	Updated	Effective 10/15/2026 No criteria changes.
Iron Replacement – Injectafer (IP0748)	Updated	Effective 10/1/2026 Added generic ferric carboxymaltose to the policy Preferencing Table. Added preferred preferencing for generic ferric carboxymaltose Effective 10/15/2026 Preferred Product Table. Added generic Venofer as an alternative

Iron Replacement – Monoferic (IP0749)	Updated	Effective 10/15/2026 Preferred Product Table. Added generic Venofer as an alternative
Lupus – Saphnelo Subcutaneous (IP0810)	Updated	Effective 10/1/2026 Policy title updated from “Lupus – Saphnelo Subcutaneous for Individual and Family Plans” to “Lupus – Saphnelo Subcutaneous”.
Mucopolysaccharidosis – Gene Therapy – Fayuvi - (IP0849)	New	Effective 10/16/2026 New policy.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM004)	Updated	Effective 10/15/2026 No criteria changes.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Individual and Family Plans - (PSM008)	Updated	Effective 10/15/2026 No criteria changes.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Standard/Performance and Total Savings Prescription Drug List Plans - (PSM015)	Updated	Effective 10/15/2026 No criteria changes.

Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Value/Advantage Prescription Drug List Plans - (PSM039)	Updated	Effective 10/15/2026 No criteria changes.
Muscular Dystrophy – Viltepso (IP0066)	Updated	Effective 10/15/2026 No criteria changes
Neurology – Gene Therapy – Kebilidi - (IP0725)	Updated	Effective 10/1/2026 Coding Information Added CPT 1083T
Oncology – Jakafi/Jakafi XR (IP0318)	Updated	Effective 10/1/2026 The policy name was changed to as listed. Previously, it was Oncology – Jakafi. Jakafi XR was added to the policy with the same criteria as Jakafi.
Ophthalmic – Glaucoma – Prostaglandins (IP0027)	Updated	Effective 10/1/2026 Zolymbus was added with the same criteria as the existing products within the policy. Employer Plans Added preferred product requirements for Zolymbus. Individual and Family Plans Added preferred product requirements for Zolymbus.
Ophthalmology – Lumvoa (IP0818)	New	Effective 10/1/2026 New Policy.
Ophthalmology - Pilocarpine 1.25% (IP0343)	Updated	Effective 10/15/2026 Policy Title: Updated from “Pilocarpine 1.25% Ophthalmic” to “Ophthalmology - Pilocarpine 1.25%”

Otolaryngology – Gene Therapy – Otarmeni - (IP0824)	Updated	Effective 10/1/2026 Coding Information Added CPT 1056T
Otolaryngology – Gene Therapy – Otarmeni - (IP0824)	Updated	Effective 10/16/2026 Policy Statement: Otarmeni can only be prescribed by a physician who specializes in the condition being treated; the qualifier “or in consultation with” was removed. It was clarified that approval is for up to two doses per patient. A statement about claims history was added and All reviews will be forwarded to a Medical Director for evaluation. Documentation: This section was added to the policy. Sensorineural Hearing Loss: “Verification in claims history required” was added to the requirement that patient is not receiving retreatment of ear(s) previously treated with Otarmeni. “Documentation required” was added to the following requirements: that patient has molecularly confirmed biallelic variants in the otoferlin (OTOF) gene; patient has severe-to-profound or profound hearing loss, as defined by > 90 decibels hearing level; patient has preserved outer hair cell function, as determine by the prescriber; and patient had preoperative imaging and access to the inner ear is feasible. For the requirement that patient did not have a prior cochlear implant in the ear to be treated with Otarmeni, the qualifier “According to the prescribing physican” was added. The specialist requirement was changed to as written; previously it was The medication is prescribed by or in consultation with an otolaryngologist. A new criterion was added – that if criteria A through G are met, approve up to two doses of Otarmeni (one dose per ear per lifetime) to be given as an intracochlear infusion; each dose is 7.2×10^{13} vector genomes in a total volume of 0.24 mL. Conditions Not Covered: “Retreatment of Previously Treated Ears”, was updated to read “Prior Receipt of Gene Therapy”.
Papillomatosis – Papzimeos (IP0765)	Updated	Effective 10/15/2026 No criteria changes.
Pharmacy and Medical Prior Authorization (1407)	Updated	Effective 10/1/2026 Added preferred product requirement criteria for the following: EFFECTIVE 10/1/2026: Cafergot, ergotamine-caffeine 1-100 mg tablets, Hemady, Captyla, and Lybalvi

		EFFECTIVE 10/15/2026: Dexlyt and Nereus Updated preferred product requirement criteria for the following: EFFECTIVE 10/1/2026: Bucapsol capsules, Rexulti, Fanapt, Cobenfy, Secuado, Gvoke HypoPen Auto-Injector, Kit, or Prefilled Syringe, Zegalogue, sumatriptan/ naproxen sodium tablets, Treximet, diclofenac epolamine 1.3% topical patch, Flector Patch (brand), Licart, and Zoryve 0.3% cream Removed preferred product requirement criteria for the following: EFFECTIVE 10/1/2026: Vesicare LS
Pheochromocytoma-Metyrosine and Phenoxybenzamine (IP0450)	Updated	Effective 10/01/2026. No criteria changes.
Psychiatry – Novel Psychotropics Drug Quantity Management Policy – Per Days (DQM022)	Updated	Effective 10/15/2026 Bysanti 1 mg, 2mg, 4 mg, 6 mg, 8 mg, 10 mg, and 12 mg tablets: New quantity limits were added to the policy of 60 tablets per dispensing at retail and 180 tablets per dispensing at home delivery. The same clinical override criteria apply to Bysanti as have previously applied to Fanapt tablets (NOT Starter Packs). Bysanti Titration Pack A: New quantity limits were added to the policy of 1 pack (8 tablets) per dispensing at retail and home delivery. No clinical override criteria apply. Bysanti Titration Pack B: New quantity limits were added to the policy of 1 pack (12 tablets) per dispensing at retail and home delivery. No clinical override criteria apply. Bysanti Titration Pack C: New quantity limits were added to the policy of 1 pack (8 tablets) per dispensing at retail and home delivery. No clinical override criteria apply.
Quantity Limitations (1201)	Updated	Effective 10/15/2026 Removed Xifaxan quantity limit exception criteria and relocated to a new policy, <i>Antibiotics – Xifaxan Drug Quantity Management Policy – Per Days – (DQM041)</i> Removed Zoryve cream and foam and relocated to a new policy, <i>Dermatology – Zoryve Drug Quantity Management Policy – Per Days – (DQM042).</i> Removed Doxepin 5% cream, Prudoxin, and Zonalon and relocated to a new policy, <i>Topical Antipruritics – Doxepin Products Drug Quantity Management Policy – Per Days – (DQM043).</i>
Regranex - (IP0495)	Updated	Effective 10/15/2026

		No criteria changes.
Rituximab Intravenous Products for Non-Oncology Indications (IP0319)	Updated	Effective 10/15/2026 No criteria changes.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) [1803]	Updated	Effective 10/1/2026 Removed Pentasa 250 mg from the 5-Aminosalicylates (5-ASAs) therapeutic category. Removed Janumet XR from the Diabetes Care therapeutic category, effective 11/1/2026.
Testosterone (Injectable) Products (IP0351)	Updated	Effective 10/15/2026 No criteria changes.
Topical Anesthetic - Lidocaine Patch Products (IP0709)	Updated	Effective 10/15/2026 Title: The policy name was changed to as listed. Previously, it was Lidocaine Patch Products. Low Back Pain: In note providing examples of pharmacologic therapies for low back pain, celecoxib was moved to the list of nonsteroidal anti-inflammatory drugs
Topical Antipruritics – Doxepin Products Drug Quantity Management Policy – Per Days - (DQM043)	New	Effective 10/15/2026 New policy. Criteria was previously located in the <i>Quantity Limitations – (1201)</i> policy.
Topical Retinoids – Tazarotene Products (IP0174)	Updated	Effective 10/15/2026 Added Trilitas 0.1% (tazarotene) gel to the policy. Individual and Family Plans Preferred Product Criteria Added criteria for Trilitas 0.1% (tazarotene) gel.
Synagis (IP0321)	Retired	Effective 10/01/2026.

Precertification Policy*	New, Updated, or Retired?	Comments
Master Precertification List	Updated	Updated prior authorization requirements are available on our websites, CignaforHCP.com and Cigna.com. Updates include existing codes that have been removed from prior authorization or terminated by AMA and CMS. New Codes: - For 10/1/2026, Cigna added 20 CPT and 17 HCPCS codes to prior authorization. Updates: - No updates for October 1, 2026.
Reimbursement Policy*	New, Updated, or Retired?	Comments
Hospital Acquired Conditions – (R19)	Updated	Hospital-Acquired Condition (HAC) examples were added to the policy to provide additional clarity and guidance.
Other Coding and Reimbursement Documents	New, Updated, or Retired?	Comments
		No updates for October 2026
ClaimsXten Documents*	New, Updated, or Retired?	Comments
Code Editing Policy and Guidelines	Updated	On November 15, 2026, ClaimsXten will be updated to Fourth Quarter Knowledge Base content and NCCI Version 32.3 for all medical and behavioral claims we process.

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