Provider News Policy Notice

Oct. 1, 2025

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. To verify when a policy is or will be in effect, please refer to the effective date listed at the beginning of each policy.

Medical Policy Revisions

Services listed in this section may be covered (considered medically necessary), if medical policy criteria are met, or non-covered (considered experimental and investigational).

Effective Jan. 1, 2026:

- **Abdominoplasty/Panniculectomy** (MP9646) — Prior authorization continues to be required. An example was added to Benefit Consideration #6 to clarify when 2 or more services performed during the same session and it is a mix of a reconstructive service and a cosmetic service, the surgeon must delineate the cosmetic and reconstructive components associated with the procedure. For example:
  - If a panniculectomy is combined with plication of the rectus abdominis muscle and/or translocation of the umbilicus, this may be completed as a single stage procedure, but the plication of the rectus abdominis muscle and/or translocation of umbilicus would be considered cosmetic and *therefore not covered*.
- **Breast Implant Removal, Revision, or Reimplantation** (MP9580) — Prior authorization continues to be required. The following additions were made:
  - In Background Section: Revised the definition of capsular contracture, including revised definitions of the four grades of the Baker grading system; and added examples of complications of breast implant.
  - In Medical Necessity Criteria: Added a new criterion for Baked Class IV capsular contraction.
- **Female Breast Reduction Surgery – Reduction Mammoplasty** (MP9582) — Prior authorization continues to be required. The following additions were made:

- In Background Section: Revised the definition of reduction mammoplasty; and added definitions for ptosis of the breast and Women's Health & Cancer Rights Act of 1998 (WHCRA).
- In Benefit Considerations: Added examples of procedure that would be considered reconstructive and not cosmetic when performed following mastectomy, including on the contralateral breast to obtain symmetry.
- In Medical Necessity Criteria: Added new criterion of documentation that the amount of breast tissue to be removed (by mass or volume) is expected to offer symptomatic relief.
- Also added additional examples of persistent functional impairments from macromastia which affect activities of daily living.

- **Male Gynecomastia** (MP9581) — Prior authorization continues to be required. The following updates were made to this policy's Medical Necessity Criteria:
  - For both adults and adolescents: functional impairment (e.g., chronic skin irritation, pain) needs to be documented in the medical record.
  - For adults only: added criteria that evidence of breast cancer is not documented; and added criteria that gynecomastia did not regress after discontinuation of medications (e.g., calcium channel blockers, cimetidine, phenothiazines, spironolactone, theophylline) known to cause condition, medications cannot be discontinued, or no medications that induce gynecomastia are being used.
  - Also currently included: The use of potential gynecomastia-inducing drugs and substances has been identified and discontinued for at least one year, when medically appropriate.
- **Rhinoplasty Procedure with or without Septoplasty** (MP9648) — Prior authorization continues to be required. A revision was made to one of the medically necessary criteria to clarify the duration of failed medical treatment prior to surgery: Replaced "failed medical treatment" with "obstructive nasal symptoms, despite conservative management for four weeks or greater, which includes where appropriate nasal steroids or immunotherapy."

Updates to Carelon Guidelines

The following Carelon guideline changes will be effective Jan. 1, 2026:

- For Management of Selected Cardiology Services, the following policy updates have been made:
  - **Diagnostic Coronary Angiography:** Removed definition of suspected CAD; and added exclusion that use of invasive FFR to create 3D map of the coronary arteries is not medically necessary.
  - **Endovascular Revascularization:** Clarified that atherectomy is only medically necessary for treatment of the femoropopliteal and tibial vessels; removed language about primary and secondary stenting; and clarified examples of abnormal hemodynamic parameters.
- For Management of Selected Radiology Services, the following policy updates have been made:
  - **Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)** is medically necessary for either: Preoperative seizure localization for intractable epilepsy, when MRI is nondiagnostic; or preoperative mapping of eloquent cortex.

New Medical Policies

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

Effective Jan. 1, 2026:

- **Air Conduction Hearing Aids (Wearable & Bone Anchored)** (MP9445) — Prior authorization is not required.
  - Air-conduction (standard wearable) hearing aids are covered when: Device is FDA-approved and used for the approved indications; hearing loss is tested within 6 months prior to the hearing aid fitting; and hearing loss is tested at the appropriate thresholds and frequencies.
  - Bone-anchored hearing aids (BAHA) are covered when: Device is FDA-approved and used for the approved indications; the individual is 5 years of age or older; hearing loss has been evaluated by a licensed audiologist; and hearing loss displays one of the following:
    - Unilateral or bilateral conductive or mixed hearing loss refractory to previous medical or surgical interventions
    - Unilateral pure sensorineural hearing loss
  - The following services or products *are considered not medically necessary and are therefore not covered*:
    - Intra-oral bone conduction hearing aids (e.g., SoundBite Hearing System)
    - Vibrant Soundbridge middle ear hearing aid
    - Over-the-counter (OTC) hearing aids (e.g., Jabra Enhance; Eargo; Lexie; Audicus; Elehear)
    - Alternative listening devices (e.g., smartphone/wireless products, personal sound amplification products/PSAPs)
    - Upgrades when: The current device is functional and/or still covered under warranty; or the request for newer technology is solely based on convenience or a desired model change.
- **Erectile Dysfunction** — Prior authorization is not required.
  - The diagnosis, assessment, and treatment of erectile dysfunction (ED; impotence) *may be medically necessary and covered* in the following circumstances: When diagnosis and assessment are done prior to the initiation of treatment for suspected ED; and treatments are undertaken when the member has documented physiologic ED and policy criteria are met.
  - The following procedures *are considered not medically necessary and are therefore not covered* in the diagnosis of ED: Corpora cavernosal electromyography; dorsal nerve conduction latencies; and evoked potential measurements.
  - **Note:** Coverage of treatments for ED is subject to the terms of the member's medical and pharmacy benefit plan. Most benefit plans exclude coverage of medications for sexual dysfunction. Please check benefit plan descriptions for details.
- **Home Oxygen Therapy** — Prior authorization is not required.
  - Short-term oxygen therapy (STOT) *is covered* for up to one month for treatment of hypoxemia-related symptoms with qualifying laboratory values associated with acute conditions included in policy criteria.
  - Long-term oxygen therapy (LTOT) *is covered* for up to 12 months for treatment of hypoxemia-related symptoms with qualifying laboratory values from chronic lung conditions including but not limited to *any* listed in the policy criteria.

- STOT or LTOT for home use *is considered not medically necessary and is therefore not covered* for the indications listed in the policy criteria.

- **Reconstructive and Cosmetic Health Services** — Prior authorization is not required.
  - For reconstructive services: A procedure *is considered reconstructive and medically necessary and therefore covered* when *all* criteria listed in the policy are met.
  - For cosmetic services: Services and procedures that improve physical appearance but do not correct or improve a physiological function *are cosmetic*, *so considered not medically necessary and therefore not covered* — unless there's documentation that the service or procedure meets the above definition of reconstructive.

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.

Pharmacy Drug Formulary Maintenance

Effective for dates of service on and after Nov. 1, 2025:

- Specialty generic program update for **Revlimid (lenalidomide), Iressa (gefitinib) and Esbriet (pirfenidone)** — Brand coverage moved to not covered.

Pharmacy Drug New Indications

Effective for dates of service on and after Nov. 1, 2025:

- **Skytrofa (lonapegsomatropin)** single-dose vials — Updated prior authorization criteria for indication in the treatment of adults with growth hormone deficiency (GHD). Prior authorization criteria will match other criteria for adults with growth hormone deficiency.

Pharmacy Drug New or Expanded Formulations

Effective for dates of service on and after Nov. 1, 2025:

- **Brukinsa (zanubrutinib)** 160 mg tablets — Moved to preferred brand/specialty tier, limited distribution (Lumicera), prior authorization, split-fill and quantity limit of 2 tablets/day.
- **Brynovin (sitagliptin)** 25 mg/mL oral solution — Moved to not covered.
- **Dexcom G7** 15-day sensor — Moved to preferred brand tier, prior authorization exception is required for patients not using insulin (insulin step therapy automated at the point-of-sale), and quantity limit of 2 sensors/month.
- **Prezcobix (darunavir-cobicistat)** 675/150 mg tablets — Moved to preferred brand.

Pharmacy Drug Prior Authorization Form Updates

Effective for dates of service on and after Nov. 1, 2025:

- PARP inhibitors **Lynparza (Olaparib), Rubraca (rucaparib) and Zejula (niraparib)** — Updated prior authorization criteria to align with U.S. Food and Drug Administration (FDA) indications for ovarian cancer and limit use to only those most likely to benefit.

Pharmacy Drug Miscellaneous Updates

Effective for dates of service on and after Nov. 1, 2025:

- **Ixchiq (chikungunya vaccine)** — Removed from travel vaccine list.

Reminder: Providers are encouraged to refer to the Prime Therapeutics website (see below) for a complete list of co-branded medical benefit drug policies — both oncology and non-oncology. *Some policies have been revised for new criteria effective Nov. 1, 2025*. 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 Medica (formerly WellFirst Health) Document Library is an online repository of medical policies, forms, manuals and other documents. For medical benefit drug policies, **refer to the Prime Therapeutics (formerly Magellan Rx) website** — *not* the Document Library.

Providers are encouraged to track updates and review policies in their entirety. The Document Library is directly accessible at **mo-central.medica.com/document-library** or by visiting **the mo-central.medica.com home page** and following the step-by-step instructions below:

- Select **Providers**, and then **Medical management home**.
- 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.

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**.