Blue Cross and Blue Shield of Nebraska is proud to work with our provider network to serve your patients, our members. We are updating several medical policies. Please review the changes and effective dates outlined here:

REVISED MEDICAL POLICIES

Medical Policy IV.82 Targeted Biopsy of the Prostate and Prostate Screening
Effective Date: 11/01/2022
Preauthorization Required: Yes
Policy Statement:

I. MRI Prostate for screening may be considered **scientifically validated** in patients who meet the following criteria:
   A. Patient has had prior TRUS biopsy **AND**
   B. Age 40-74 years old with a PSA >3 and/or abnormal digital rectal exam **OR**
   C. Age 75 years of age or older with a PSA ≥4 and/or abnormal digital rectal exam

II. MRI Prostate for screening is considered **investigational** when the above criteria are not met as its clinical effectiveness has not been established

III. Repeat MRI Prostate for screening may be considered **scientifically validated** in patients who meet **ALL** the following:
   A. It has been at least 6 months since the last prostate MRI **AND**
   B. PSA remains elevated **AND/OR**
   C. Abnormal digital rectal exam (DRE)

IV. Repeat MRI Prostate for screening is considered **investigational** for all other indications as its clinical effectiveness has not been established.

Medical Policy III.105 Procedures to Treat Dysmenorrhea and Uterine Fibroids
Effective Date: 08/17/2022
Preauthorization Required: Yes
Policy Statement:

I. Laparoscopic or transcervical radiofrequency ablation (RFA) as a treatment of symptomatic uterine fibroids may be considered **medically necessary** in women 18 years and older when **ALL** the following conditions are met:
   A. Evidence of uterine fibroids via ultrasound that are less than 10 cm in diameter for laparoscopic RFA (with Acessa) or 7 cm for transcervical RFA (with Sonata); **AND**
   B. Patient desires a uterine-sparing treatment approach or is ineligible for hysterectomy or other uterine-sparing alternatives to RFA (e.g., laparoscopic myomectomy, uterine artery embolization [UAE]) (see Policy Guidelines*); **AND**
   C. Patient has experienced at least 1 of the following symptoms that are a direct result of the fibroid(s):
      1. Menorrhagia or other abnormal uterine bleeding that interferes with daily activities or causes anemia (see Policy Guidelines*); **OR**
      2. Pelvic pain or pressure; **OR**
      3. Urinary symptoms (e.g., urinary frequency, urgency) related to bulk compression of the bladder; **OR**
      4. Gastrointestinal symptoms related to bulk compression of the bowel (e.g., constipation, bloating); **OR**
      5. Dyspareunia (painful or difficult sexual relations).

II. Other laparoscopic, transcervical, or percutaneous techniques for myolysis of uterine fibroids, including use of laser or bipolar needles, cryomyolysis, and magnetic resonance imaging-guided laser ablation, are considered **investigational**.

III. Open and laparoscopic uterine nerve ablation and presacral neurectomy for dysmenorrhea are considered investigational.

Medical Policy III.218 Spinal Cord and Dorsal Ganglion Root Stimulator
Effective Date: 09/07/2022
Preauthorization Required: Yes
New Indication

Peripheral Diabetic Neuropathy

1. Patient is 18 years of age or older **AND**
2. Patient has refractory pain or burning in area **AND**
3. Patient has **two** of the following:
   a. numbness
   b. sensory loss
   c. paresthesia

AND

4. Patient has tried and failed all of the following:
   a. sympathetic block **AND**
   b. home exercise, occupational therapy, or physical therapy for 6 months or more **AND**
   c. antidepressant or antiepileptic drugs for 4 weeks or more

AND

5. Patient does **NOT** have any of the following:
   a. untreated or uncontrolled psychiatric disorder
   b. drug or alcohol misuse (patient must be alcohol free for at least 4 weeks)
   c. active immunosuppression
   d. bleeding disorder
   e. systemic or localized infection at operative site
   f. cardiac pacemaker, implantable cardioverter or other neurostimulator
   g. pregnant

NEW PHARMACY POLICIES

Medical Policy TBD: Norliqva
Effective: 9/1/22
Preauthorization Required: Yes
Policy Statement: Norliqva is considered not medically necessary as there is no published clinical data indicating that Norliqva is more efficacious than the more cost-effective generic amlodipine tablets.

Medical Policy TBD: Tavneos
Effective: 9/1/22
Preauthorization Required: Yes
Policy Statement: Medically necessary as adjunctive treatment of adult patients with severe active anti-neutrophil cytoplasmic autoantibody (ANCA) associated vasculitis (granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)) in combination with standard therapy, including glucocorticoids.

Medical Policy TBD: Livtencity
Effective: 9/1/22
Preauthorization Required: Yes
Policy Statement: Medically necessary for the treatment of adult and pediatric patients (12 years of age and older weighing at least 35kg) with post-transplant cytomegalovirus (CMV) infection/disease that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir, or foscarnet.

Medical Policy TBD: Camzyos
Effective: 9/1/22

Preauthorization Required: Yes
Policy Statement: Medically necessary for the treatment of adults with symptomatic New York Heart Association (NYHA) class OO-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms.

Medical Policy TBD: Oxbryta
Effective: 9/1/22
Preauthorization Required: Yes

Policy Statement: Medically necessary for the treatment of sickle cell disease (SCD) in adult and pediatric patients (age 4 years of age and older).

Medical Policy X.19: Denosumab (Prolia and Xgeva)
Effective: 9/1/22
Preauthorization Required: Yes
Policy Statement: Updated criteria to allow for evidence of high fracture risk to include fracture history, presence of fragility fracture, or FRAX score only in diagnosis of osteopenia. For diagnosis of osteoporosis criteria to only required patient have failure of bisphosphonate as updated guidelines do list denosumab as alternate first-line therapy for treatment of osteoporosis.

REVISED PHARMACY POLICIES

Medical Policy X.179 -Pegfilgrastim – addition of preferred biosimilars and addition of Fylnetra (pegfilgrastim-pbbk)

Medical Policy X.2 -Topical Acne Agents- addition of criteria to require use of generic products prior to approval of branded products for patients under 40 years of age.

Medical Policy X.42-Biologics for rheumatic disorders and hidradenitis suppurativa - addition of criteria for use of Olumiant for diagnosis of alopecia areata

Medical Policy X.124 -Self-administered Oncology Agents - addition of Vijoice

Medical Policy I.0 -Medical Necessity Review - addition of Kimmtrak

Medical Policy X.122 -Therapeutic Alternatives - addition of Adlarity, citalopram 30mg capsules, Vtama Cream, Verkazia, Soaanz, Ermeza

Medical Policy X.109 -Topical Antibiotics and Combinations Step Therapy - addition of Epsolay

Medical Policy I.164 -Zostavax/Shingrix - addition of criteria for use of ages 18 years and older who are at or will be at increased risk of HZ due to immunodeficiency or immunosuppression by known disease or therapy