Blue Cross and Blue Shield of Nebraska (BCBSNE) 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:

NEW MEDICAL POLICIES

Medical Policy: Prostate Rectal Spacers (SpaceOAR Hydrogel)
Effective Date: 08/01/2022
Preauthorization Required: Yes
Policy Statement:

I. Prostate rectal spacers (SpaceOAR Hydrogel) **may be considered medically necessary** when **ALL** following criteria are met:

A. Patient has a diagnosis of localized or locally advanced prostate cancer (T1-T3) with no lymph node involvement **AND**
B. The patient will undergo hypofractionated radiation therapy (hypofractionated-IMRT, hypofractionated high dose rate brachytherapy, hypofractionated EBRT, or stereotactic body radiotherapy) **AND**
C. The prostate volume is less than 80 cc **AND**
D. Patient has had no prior surgery or radiation for prostate cancer treatment **AND**
E. Patient has no active bleeding or platelet count <100×10(9)/l, an international normalized ratio >1.5, or activated partial thromboplastin time >50 seconds **AND**
F. There is no tumor invasion into the rectum and no posterior extraprostatic extension (local tumor growth beyond the fibromuscular pseudocapsule of the prostate gland into the periprostatic soft tissues

II. Prostate rectal spacers are not medically necessary when the above criteria are not met.

Medical Policy: Spinal Cord Tethering
Effective Date: 08/01/2022
Preauthorization Required: Yes
Policy Statement:

I. Spinal Cord Tethering is considered **investigational** for all clinical indications, including idiopathic scoliosis

Medical Policy: Piriformis Syndrome Surgery
Effective Date: 08/01/2022
Preauthorization Required: Yes
Policy Statement:

I. Piriformis syndrome surgery is **investigational** for all indications.

REVISED MEDICAL POLICIES

Medical Policy: Durable Medical Equipment
Effective Date: 08/01/2022
Preauthorization Required: Yes
Policy Statement:

I. Blood ketone monitoring devices for epilepsy prescribed ketogenic diets are **investigational.**

NEW PHARMACY POLICIES

Medical Policy X.193: Fyarro
Effective: 6/1/2022
Preauthorization Required: Yes
Policy Statement: Medically necessary for the treatment of adult patients with locally advanced unresectable or metastatic malignant perivascular epithelioid tumor (PEComa).

Medical Policy X.194: Radioligand Agent Therapy
Effective: 6/1/2022
Preauthorization Required: Yes
Policy Statement: Lutathera is medically necessary for the treatment of somatostatin-positive, gastroenteropancreatic neuroendocrine tumor (GEP-NETS) after treatment of somatostatin analog. Pluvicto is medically necessary for the treatment of adult patients with prostate-specific membrane antigen (PSMA)-positive metastatic castration-resistant prostate cancer (mCRPC) who have been treated with androgen receptor (AR) pathway inhibition and taxane-based therapy.

Medical Policy X.195: Enjaymo
Effective: 6/1/2022
Preauthorization Required: Yes
Policy Statement: Medically necessary to decrease the need for red blood cell (RBC) transfusions due to hemolysis in adults with cold agglutinin disease (CAD).

Medical Policy X.196: Pyrukynd
Effective: 6/1/2022
Preauthorization Required: Yes
Policy Statement: Medically necessary for the treatment of hemolytic anemia in adults with pyruvate kinase (PK) deficiency.

Medical Policy X.197: New to Market Medical Necessity Policy
Effective: 7/1/2022
Preauthorization Required: Yes
Policy Statement: Medications new to market will be considered not medically necessary until reviewed by Medical Policy Committee for clinical effectiveness and medical necessity criteria.

Medical Policy X.15: Hereditary Angioedema Treatment and Prophylaxis
Effective: 6/1/2022
Preauthorization Required: Yes
Policy Update: Medical necessity criteria will now require submission of swelling diaries or journals for review.

REVISED PHARMACY POLICIES

Medical Policy X.153 -Intravitreal Injections for Retinal Conditions - addition of Byooviz, Susvimo, Vabysmo

Medical Policy X.124 -Self-Administered Oncology Agents- addition of Vonjo

Medical Policy I.0 -Procedures for Medical Review - addition of Tivdak

Medical Policy X.145 -Constipation agents - addition of Ibsrela as non-preferred product

Medical Policy X.2 -Topical Acne Agents - addition of Twyneo

Medical Policy X.55-Programmed Cell Death (PD-1) Inhibitor - addition of Opdualag

Medical Policy X.94 -Chimeric Antigen Receptor (CAR-T) T-cell Therapy - addition of Carvykti

Medical Policy X.147 -Vascepa – update to list brand Vascepa as preferred product; generic icosapent ethyl capsules are non-preferred

Medical Policy X.86 -Attention Deficit (Hyperactivity) Disorder (ADHD/ADD) Agents– addition of Xelstrym (dextroamphetamine) transdermal system

Medical Policy X.66 -Androgens - addition of Tlando