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: V.78 Laboratory Testing for Cardiac Transplant Rejection
Effective: 04/01/2022
Preauthorization Required: Yes
Policy Statement:

AlloMap gene expression profiling (GEP) may be considered **medically necessary** as a non-invasive method of determining the risk of rejection in heart transplant recipients > 15 years of age, who are between six months and five years post-heart transplant, AND

- Recipient must have stable heart allograft function demonstrated by ALL the following:
  - Left ventricular ejection fraction ≥ 45% which has been confirmed by echocardiogram
  - No evidence of CHF
  - No evidence of severe cardiac allograft vasculopathy AND

Recipient must have a low probability of moderate or severe acute cellular rejection as demonstrated by the ALL of the following:

- Clinical assessment (e.g., International Society for Heart and Lung Transplantation rejection status Grade of 0R or 1R)
- No history or evidence of antibody-mediated rejection

REVISED MEDICAL POLICIES

Medical Policy: III.224 Organ Transplant Surgery
Effective: 04/01/2022
Preauthorization Required: Yes
Policy Statement:

The following transplants will require a preauthorization: liver, heart, single and double lung, lobar lung, heart-lung, heart valve (heterograft), kidney kidney-pancreas, pancreas, bone graft, cornea, parathyroid, small intestine, small intestine and liver, small intestine and multiple - viscera, bone marrow transplants, including but not limited to autologous and allogeneic stem cell transplants.

Medical Policy: V.21 Measurement of Serum Antibodies to Infliximab and Adalimumab
Effective: 04/01/2022
Preauthorization Required: Yes
Policy Statement:

Adding CPT 83520 for Rheumatoid arthritis, Crohn's Disease, Ulcerative Colitis, Ankylosing Spondylitis, Psoriatic arthritis, and Plaque Psoriasis

Medical Policy: X.66 Androgen
Effective: 04/01/2022
Preauthorization Required: Yes
Policy Statement:

Use of testosterone cypionate (J1070**)** may be considered **medically necessary** as an off-label use for the treatment of the following conditions:

- Female-to-male transgender reassignment, in the management of gender identity disorder

All other uses of **testosterone cypionate** are considered **investigational** including, but not limited to, their use in the treatment of pediatric patients (unless for delayed puberty), sexual dysfunction in both men (e.g., erectile dysfunction) and women (e.g., decreased libido), post-menopausal symptoms, depression, and for the enhancement of athletic performance