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Subject: Eptinezumab-jjmr (Vyepti™)

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DESCRIPTION:

Migraine and Cluster Headache Management

Migraine is a common disabling primary headache disorder with high prevalence, ranking second globally in terms of years lost to disability.(5) Typical characteristics of the headache are unilateral location, pulsating quality, moderate or severe intensity, aggravation by routine physical activity, and association with nausea and/or photophobia and phonophobia. Migraines can present with or without aura, unilateral fully reversible visual, sensory, or other central nervous system symptoms that usually develop gradually and are most-often followed by headache and associated migraine symptoms.(3)

The International Classification of Headache Disorders 3rd Edition (ICHD-3) Diagnostic Criteria:(3)

Indication	Diagnostic Criteria
Migraine without aura	A. At least five attacks fulfilling criteria B-D B. Headache attacks lasting 4-72 hours (untreated or unsuccessfully treated) C. Headache has at least TWO of the following: 1. unilateral location 2. pulsating quality 3. moderate to severe pain intensity

	4. aggravation by causing avoidance of routine physical activity D. During headache at least ONE of the following: 1. nausea and/or vomiting 2. photophobia and phonophobia E. Not better accounted for by another ICHD-3 diagnosis
Migraine with aura	A. At least two attacks fulfilling criteria B and C B. One or more of the following fully reversible aura symptoms: 1. visual 2. sensory 3. speech and/or language 4. motor 5. brainstem 6. retinal C. At least THREE of the following: 1. at least one aura symptom spreads gradually over 5 minutes or more 2. two or more aura symptoms occur in succession 3. each individual aura symptom lasts 5-60 minutes 4. at least one aura symptom is unilateral 5. at least one aura symptom is positive 6. the aura is accompanied, or followed within 60 minutes, by headache D. Not better accounted for by another ICHD-3 diagnosis
Chronic Migraine	A. Headache (migraine-like or tension-type-like) on greater than or equal to 15

	days/month for greater than 3 months AND fulfilling B and C B. Occurring in patient who has had at least 5 attacks fulfilling 1. criteria B-D for migraine without aura (noted above) and/or 2. criteria B and C for migraine with aura (noted above) C. On greater than or equal to 8 days/month for greater than 3 months, fulfilling any of the following: 1. criteria C and D for migraine without aura (noted above) 2. criteria B and C for migraine with aura (noted above) 3. believed by the patient to be migraine at onset and relieved by a triptan or ergot derivative D. Not better accounted for by another ICHD-3 diagnosis
Cluster Headache	A. At least 5 attacks fulfilling criteria B-D B. Severe to very severe unilateral orbital, supraorbital and/or temporal pain lasting 15-180 minutes (untreated) C. At least one of the following: 1. At least one of the following signs or symptoms, ipsilateral to the headache a. conjunctival injection and/or lacrimation b. nasal congestion and/or rhinorrhea c. eyelid edema d. forehead and facial sweating e. miosis and/or ptosis 2. Sense of restlessness or agitation

	D. Occurring with frequency between one every other day and 8 per day E. Not better accounted for by another ICHD-3 diagnosis
Episodic Cluster Headache	A. Attacks fulfilling criteria for Cluster Headache (noted above) occurring in bouts (cluster periods) B. At least two cluster periods lasting 7 days to 1 years (untreated) and separated by pain-free remission periods of at least 3 months

The IHS notes that cluster periods usually last between 2 weeks and 3 months.(3)

Migraine prevention may be of benefit in those with the following:(5,6,11)

- Frequent or long-lasting migraine headaches (greater than 4 headaches/month or headaches lasting greater than 12 hours)
- Attacks interfere significantly with patients' daily routines despite acute treatment
- Contraindication to acute therapies
- Failure of acute therapies
- Adverse effects with acute therapies
- Risk of medication overuse headache (MOH)
- Patient preference

The American Headache Society (AHS) and the American Academy of Neurology (AAN) suggest the following agents for the prevention of migraine:(2)

- Established as effective (Level A)
    - Antiepileptic drugs (AEDs)
        - Divalproex
        - Valproate
        - Topiramate
    - Beta blockers
        - Metoprolol
        - Propranolol
        - Timolol
    - Triptans
        - Frovatriptan for short term menstrually associated migraines (MAMs) prevention

- Probably effective (Level B)
    - Antidepressants
        - Amitriptyline
        - Venlafaxine
    - Beta blockers
        - Atenolol
        - Nadolol
    - Triptans
        - Naratriptan, zolmitriptan for short term MAMs prevention

The 2021 American Headache Society Consensus Statement recommends the following indications for initiating treatment acute treatment with gepants and ditans agents:(11)

- Prescribed by a licensed clinician
- Patient is at least 18 years of age
- Diagnosis of ICHD-3 migraine with aura, migraine without aura, or chronic migraine
- Either of the following:
    - Contraindication to or inability to tolerate triptans
    - Inadequate response to two or more oral triptans, as determined by either of the following:
        - Validated acute treatment patient-reported outcoming questionnaire (mTOQ, Migraine-ACT, PPMQ-R, FIS, PGIC)
        - Clinician attestation

Lasmiditan is a selective serotonin 5HT-1F receptor agonist that lacks vasoconstrictor activity. Lasmiditan is structurally different than triptans and therefore constitutes a new class of drugs called "ditans".(11) Ditans are selective for the 5HT-1F receptor and its mechanism of action is neuronal without evidence of vasoactive effects.(15) Triptans non-specifically bind to the 5HT-1B and 5HT-1D receptors and with varying affinity bind the 5HT-1F receptors, causing direct vascular vasoconstriction. The safety, tolerability, and efficacy of co-administering lasmiditan with a triptan or a gepant has not been assessed.(11) Patients who do not respond to initial therapy with a triptan, may benefit from a second triptan or different therapy such as use of a gepant (ubrogepant or rimegepant) or a ditan (lasmiditan).(5)

The 2021 American Headache Society Consensus Statement recommends the following indications for initiating treatment with a Calcitonin Gene-Related Peptide (CGRP) agent:(11)

- Prescribed by a licensed clinician
- Patient is at least 18 years of age
- ONE of the following:

- Diagnosis of migraine with or without aura (4-7 monthly headache days) and both of the following:
    - Inability to tolerate (due to side effects) or inadequate response to an 8-week trial of at least two of the following:
        - Topiramate
        - Divalproex sodium/valproate sodium
        - Beta blocker: metoprolol, propranolol, timolol, atenolol, nadolol
        - Tricyclic antidepressant: amitriptyline, nortriptyline
        - Serotonin-norepinephrine reuptake inhibitor: venlafaxine, duloxetine
        - Other Level A or B treatment according to AAN-AHS guideline
    - At least moderate disability (Migraine Disability Assessment Questionnaire [MIDAS] greater than or equal to 11, Headache Impact Test-6 [HIT]-6 greater than 50)
- Diagnosis of migraine with or without aura (8-14 monthly headache days[MHDs]) and inability to tolerate (due to side effects) or inadequate response to an 8-week trial of at least two of the following:
    -
        - Topiramate
        - Divalproex sodium/valproate sodium
        - Beta blocker: metoprolol, propranolol, timolol, atenolol, nadolol
        - Tricyclic antidepressant: amitriptyline, nortriptyline
        - Serotonin-norepinephrine reuptake inhibitor: venlafaxine, duloxetine
        - Other Level A or B treatment according to AAN-AHS guideline
- Diagnosis of chronic migraine and one of the following:
    - Inability to tolerate (due to side effects) or inadequate response to an 8-week trial of at least two of the following:
        - Topiramate
        - Divalproex sodium/valproate sodium
        - Beta blocker: metoprolol, propranolol, timolol, atenolol, nadolol
        - Tricyclic antidepressant: amitriptyline, nortriptyline
        - Serotonin-norepinephrine reuptake inhibitor: venlafaxine, duloxetine
        - Other Level A or B treatment according to AAN-AHS guideline
    - Inability to tolerate or inadequate response to a minimum of two quarterly injection (6 months) of onabotulinum toxin A

The Medical Letter Treatment Guidelines (2023) and Institute for Clinical Systems Improvement Guideline Diagnosis and Treatment of Migraine Headache - Drugs for Migraine states that a triptan is the

drug of choice for moderate to severe migraine. The short-acting oral serotonin (5-HT1B/1D) receptor agonists (triptans) sumatriptan (IMITREX, and others), almotriptan (Axert, and generics), eletriptan (RELPAX), rizatriptan (Maxalt, and generics), and zolmitriptan (Zomig, and generics) are similar in efficacy.(12,13) Onset of pain relief generally occurs 30-60 minutes after administration. The longer-acting oral triptans naratriptan (Amerge, and generics) and frovatriptan (Frova, and generics) have a slower onset of action and lower initial response rate than other triptans, but they are better tolerated. Patients with migraine who have nausea or vomiting may not be able to take an oral triptan. Intranasal triptan formulations have a more rapid onset of action than oral tablets, but their efficacy is partially dependent on GI absorption of the portion of the dose that is swallowed. Use of sumatriptan nasal powder (ONZETRA Xsail) results in a faster rise in sumatriptan plasma concentrations and higher peak concentrations than use of a similar dose of sumatriptan nasal spray, suggesting that a larger portion of the dose is absorbed intranasally with the powder. Subcutaneously administered sumatriptan relieves pain faster (in about 10 minutes) and more effectively than other triptan formulations, but it causes more adverse effects.(13)

American Headache Society (AHS) (2015): Triptans (almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan [oral, nasal spray, injectable, transcutaneous patch], zolmitriptan [oral and nasal spray]) are effective (Level A) and considered by AHS guidelines (2015) to be the gold standard for acute treatment of moderate to severe migraine headaches.(6) Dihydroergotamine is recommended for use as a second- or third-line therapy for select patients or for those with refractory migraine. Intranasal dihydroergotamine has strong evidence of effectiveness but more adverse effects than triptans because of its decreased receptor specificity.(4) An assessment of new migraine treatments by the AHS (2018; updated 2021) reaffirms previous migraine guidelines. The update lists triptans, dihydroergotamine, the oral gepants (Nurtec ODT [rimegepant] and UBRELVY [ubrogepant]), and REYVOW (lasmiditan) as effective treatment of moderate or severe acute attacks and mild to moderate attacks that respond poorly to non-specific nonsteroidal anti-inflammatory drugs (NSAIDs), non-opioid analgesics, acetaminophen, or caffeinated combinations (e.g., aspirin/acetaminophen/caffeine). The recommendation remains that prescribers must consider medication efficacy and potential medication-related adverse effects, potential adverse events, patient-specific contraindications to use with a particular medication, and drug-drug interactions when prescribing acute medications for migraine.(5,6,11)

The American Academy of Neurology (AAN) 2010 Guideline: Acute and preventive pharmacologic treatment of Cluster Headache (CH) state that sumatriptan subcutaneous injection and zolmitriptan nasal spray are first-line options for acute treatment of CH.(10,12) Since the publication of the 2010 AAN review, and re-reviewed in 2016, there is no new data from randomized, double-blind, controlled trials that contribute to determining the efficacy or safety for a number of acute treatments, including specifically sumatriptan and zolmitriptan. For acute treatment, sumatriptan subcutaneous, zolmitriptan nasal spray, and high flow oxygen remain the treatments with a Level A recommendation.(14) Guidelines suggest that prophylactic therapy should be started and continued for the duration of the CH period. Prophylactic pharmacological therapy includes verapamil, corticosteroids, lithium, topiramate, melatonin, gabapentin, valproic acid, ergotamine, and capsaicin. Verapamil is commonly considered the first option for prophylactic therapy in practice.(10,19,20) Corticosteroids can be used as transitional or bridging therapy until another prophylaxis agent is established.(19) Corticosteroids may be used by some practitioners for short periods of CH.(10,20) The American

Academy Neurology lists the following agents as option that maybe considered or should be advised as preventative treatments:

- Civamide
- Suboccipital steroid injection
- Melatonin
- Verapamil
- Lithium

The European Headache Federation and WHO consensus article (2019) states the following:(7)

- Individuals with migraine headaches should always be managed in primary care with the exception being chronic migraine, which likely requires specialist management
- Any headache not responding satisfactorily in primary care or chronic migraine, should be referred to a specialist
- In adults and children, regular high frequency use (greater than 2 day/week) of acute medication risks the development of MOH
- Treatment of episodic acute migraine headaches should be approached in a step wise manner and should treat three attacks at each step before moving to the next step if needed:
    - Step 1:
        - Use non-opioid analgesics, plus an antiemetic when needed
    - Step 2 for adults:
        - Use triptan products
        - Triptans should not be used regularly for 10 or more days per month to avoid the risk of MOH
        - Triptan efficacy is highly variable between individuals, so patients should try different triptans and formulations. Sumatriptan subcutaneous injection should be considered when all other triptans are ineffective.
        - When vomiting is present, zolmitriptan nasal spray or sumatriptan subcutaneous injection may be preferred
    - Step 2 for children and adolescents:
        - Failure of Step 1 in children should lead to specialist referral. No specific anti-migraine drugs have shown efficacy in children under 12 years of age.
        - Failure of Step 2 in adolescents (12-17 years of age), the following have shown efficacy and are approved:
            - Sumatriptan nasal spray
            - Zolmitriptan nasal spray
- Episodic migraine prophylaxis:
    - Indication for migraine prophylaxis include:

        - Attacks cause disability on two or more days per month, and
        - Acute therapy has been optimized but does not prevent this, or is poorly tolerated, or there is a risk of over-frequent use of acute therapy, even when it is effective, and
        - Patient is willing to take daily medication
        - Failure of acute therapy is an indication for migraine prophylaxis
        - For children, frequent absence from school is an additional indication for prophylaxis
    - Migraine prophylaxis agents may take 2-3 months to show efficacy
    - Children requiring prophylactic medication should be referred to a specialist
    - Medications which are effective in adult prophylaxis of episodic migraine include:
        - Beta blockers:
            - Atenolol, bisoprolol, metoprolol, propranolol
        - Amitriptyline
        - Topiramate
        - Candesartan
        - Sodium valproate
        - Flunarizine
        - CGRP
    - Onabotulinum toxin A is not effective in episodic migraine and not recommended
    - When prophylaxis therapy fails:
        - May be due to subtherapeutic dosage or duration of therapy
        - Failure of one therapy does not predict the failure of another therapy in a different class
        - Review of the following are recommended:
            - Diagnosis
            - Adherence
            - Other medications, especially for MOH causes
        - The prophylaxis therapy should be discontinued if it fails to show clear benefit
        - If all prophylaxis therapies fail, a specialist should be referred
- Chronic migraine management:
    - Chronic migraine patients should be referred to a specialist
    - Medications with efficacy in chronic migraine include:
        - Topiramate

        - Onabotulinum A
        - CGRP
- Cluster Headache management:
    - Patients should be referred to a specialist
    - Acute therapies include:
        - Triptans:
            - Sumatriptan subcutaneous injection
            - Sumatriptan nasal spray
            - Zolmitriptan nasal spray
        - Oxygen
    - Transition and maintenance therapies include:
        - Prednisone
        - Greater occipital nerve blockade
        - Verapamil
        - Lithium carbonate
        - Topiramate
    - Neuromodulation is another treatment option
    - Failure of one prophylactic therapy does not predict the failure of other therapies
    - Combination prophylaxis therapy can be considered though the potential for toxicity is high
    - Long-term prophylaxis therapy may need to be continued

The European Headache Federation guideline states the following on combining migraine prophylaxis therapy:(8)

- In episodic migraine, guidelines suggest to stop oral prophylaxis migraine agents before starting CGRPs, unless the patient previously had chronic migraine prior to prophylaxis. In such patients, the suggestion is to add CGRP to the ongoing oral prophylaxis therapy
- In chronic migraine, guidelines suggest to add CGRP to ongoing oral prophylaxis therapy
- In chronic migraine patients on onabotulinum A therapy and are receiving inadequate treatment response, guidelines suggest to stop onabotulinum A therapy before starting CGRPs
- In patients with chronic migraine who are on treatment with CGRP and may benefit from additional prevention, guidelines suggest to add on oral preventative agents
- In patients with medication overuse, guidelines suggest to use CGRPs before or after withdrawal of acute medications

The clinical trials referenced in FDA labeled package inserts for the preventative CGRP agents excluded patients that had received botulinum toxin within 4 months prior to receiving the CGRP agent.(9,16,17,18) However the 2021 American Headache Society consensus statement states that

CGRP monoclonal antibody treatment (e.g., eptinezumab-jjmr, erenumab, fremanezumab, galcanezumab) may be added to greater than or equal to one established preventative treatment, based on clinical judgement, in adults who meet the ICHD-3 criteria for the following conditions:(3,11)

- Migraine with/without aura (4–7 monthly migraine days [MMDs]) with at least moderate disability (Migraine Disability Assessment greater than or equal to 11 or 6-item Headache Impact Test greater than 50) and failure of an 8-week trial of greater than or equal to 2 preventive treatments with established efficacy (e.g., topiramate, divalproex sodium, beta-blocker, tricyclic antidepressant, and others)
- Migraine with/without aura (8–14 MMDs) and failure of an 8-week trial of greater than or equal to 2 established preventive treatments
- Chronic migraine (greater than or equal to 15 MMDs) with any level of disability and either failure of an 8-week trial of greater than or equal to two established preventive treatments or inadequate tolerability or response to onabotulinum toxin A for two quarterly injections

Medication overuse headache (MOH)

The European Headache Federation and WHO consensus article (2019) states the following:(7)

- Prevention is preferred
- The four objectives of management are:
    - Stop the overused medication
    - Recovery from MOH
    - Review and reassess the underlying headache disorder
    - Prevent relapse while allowing acceptable use of medications
- Comorbidities may require management

Safety

Vyepti is contraindicated in patients with serious hypersensitivity to eptinezumab-jjmr or to any of the excipients.

POSITION STATEMENT:

Initiation of eptinezumab-jjmr (Vyepti) **meets the definition of medical necessity** when **ALL** of the following criteria are met:

1. **ONE** of the following:
    a. The requested agent is being used for migraine prophylaxis **AND ALL** of the following:
        i. **ONE** of the following:
            1) The member has at least 15 headache days per month of migraine-like or tension-like headache for a minimum of 3 months (chronic migraine) AND BOTH of the following:

a) ≥8 migraine headache days per month for a minimum of 3 months

b) The requested agent is FDA approved for migraine prophylaxis

OR

2) The member has 4 to 14 headache days per month (episodic migraine) **AND** the requested agent is FDA approved for episodic migraine prophylaxis

ii. **ONE** of the following:

1) The patient has **ONE** of the following to **TWO** injectable CGRPs for migraine prophylaxis (e.g., Aimovig [erenumab], AJOVY [fremanezumab], Emgality [galcanezumab]):

a) A trial and inadequate response

b) An intolerance or hypersensitivity that is not expected to occur with the requested agent

2) The patient has an FDA labeled contraindication to **ALL** injectable CGRPs for migraine prophylaxis (e.g., Aimovig [erenumab], AJOVY [fremanezumab], Emgality [galcanezumab]) that is not expected to occur with the requested agent

iii. Medication overuse headache has been ruled out

b. The member has another FDA approved indication for the requested agent and route of administration

c. The member has another indication that is supported in compendia (AHFS, or DrugDex 1 or 2a level of evidence) for the requested agent and route of administration

2. If the member has an FDA labeled indication, then **ONE** of the following:

a. The members's age is within FDA labeling for the requested indication for the requested agent

b. There is support for using the requested agent for the member's age for the requested indication

3. The member will **NOT** be using the requested agent in combination with another prophylactic CGRP agent

4. The member does **NOT** have any FDA labeled contraindications to the requested agent

5. The requested quantity (dose) is within FDA labeled dosing (or supported in compendia) for the requested indication

Length of Approval: 6 months

Continuation of eptinezumab-jjmr (Vyepti) **meets the definition of medical necessity** when **ALL** of the following criteria are met:

1. Authorization/reauthorization has been previously approved by Florida Blue or another health plan in the past two years for migraine prophylaxis OR the member has previously met all indication-specific criteria.

2. **ONE** of the following:

a. ALL of the following:

i. The requested agent is being used for migraine prophylaxis

ii. The prescriber has provided information indicating improvement in migraine prevention (e.g., reduced migraine headache days, reduced migraine frequency, reduced use of acute abortive migraine medication) with the requested agent

iii. Medication overuse headache has been ruled out

b. The requested agent is being used for an indication other than migraine prophylaxis **AND** has had clinical benefit with the requested agent

3. The member will **NOT** be using the requested agent in combination with another prophylactic CGRP agent
4. The member does **NOT** have any FDA labeled contraindications to the requested agent
5. The requested quantity (dose) is within FDA labeled dosing (or supported in compendia) for the requested indication

Length of Approval: 12 months

DOSAGE/ADMINISTRATION:

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FDA-approved

- 100 mg as an intravenous infusion over approximately 30 minutes every 3 months
- Some patients may benefit from a dosage of 300 mg

Dose Adjustments

- None

Drug Availability

- 100 mg/mL solution in a single-dose vial

PRECAUTIONS:

Boxed Warning

- None

Contraindications

- Hypersensitivity

Precautions/Warnings

- Hypersensitivity Reactions: Reactions have included angioedema, urticaria, facial flushing, and rash. If a hypersensitivity reaction occurs, consider discontinuing and initiate appropriate therapy

BILLING/CODING INFORMATION:

The following codes may be used to describe:

HCPCS Coding

J3032	Injection, eptinezumab-jjmr, 1 mg

ICD-10 Diagnosis Codes That Support Medical Necessity

G43.001	Migraine without aura, not intractable, with status migrainosus
G43.009	Migraine without aura, not intractable, without status migrainosus
G43.011	Migraine without aura, intractable, with status migrainosus
G43.019	Migraine without aura, intractable, without status migrainosus
G43.101	Migraine with aura, not intractable, with status migrainosus
G43.109	Migraine with aura, not intractable, without status migrainosus
G43.111	Migraine with aura, intractable, with status migrainosus
G43.119	Migraine with aura, intractable, without status migrainosus
G43.401	Hemiplegic migraine, not intractable, with status migrainosus
G43.409	Hemiplegic migraine, not intractable, without status migrainosus
G43.411	Hemiplegic migraine, intractable, with status migrainosus
G43.419	Hemiplegic migraine, intractable, without status migrainosus
G43.501	Persistent migraine aura without cerebral infarction, not intractable, with status migrainosus
G43.509	Persistent migraine aura without cerebral infarction, not intractable, without status migrainosus
G43.511	Persistent migraine aura without cerebral infarction, intractable, with status migrainosus
G43.519	Persistent migraine aura without cerebral infarction, intractable, without status migrainosus
G43.601	Persistent migraine aura with cerebral infarction, not intractable, with status migrainosus
G43.609	Persistent migraine aura with cerebral infarction, not intractable, without status migrainosus
G43.611	Persistent migraine aura with cerebral infarction, intractable, with status migrainosus
G43.619	Persistent migraine aura with cerebral infarction, intractable, without status migrainosus
G43.C0	Periodic headache syndromes in child or adult, not intractable
G43.C1	Periodic headache syndromes in child or adult, intractable
G43.E01	Chronic migraine with aura, not intractable, with status migrainosus
G43.E09	Chronic migraine with aura, not intractable, without status migrainosus
G43.E11	Chronic migraine with aura, intractable, with status migrainosus

G43.E19	Chronic migraine with aura, intractable, without status migrainosus
G43.701	Chronic migraine without aura, not intractable, with status migrainosus
G43.709	Chronic migraine without aura, not intractable, without status migrainosus
G43.711	Chronic migraine without aura, intractable, with status migrainosus
G43.719	Chronic migraine without aura, intractable, without status migrainosus
G43.801	Other migraine, not intractable, with status migrainosus
G43.809	Other migraine, not intractable, without status migrainosus
G43.811	Other migraine, intractable, with status migrainosus
G43.819	Other migraine, intractable, without status migrainosus
G43.821	Menstrual migraine, not intractable, with status migrainosus
G43.829	Menstrual migraine, not intractable, without status migrainosus
G43.831	Menstrual migraine, intractable, with status migrainosus
G43.839	Menstrual migraine, intractable, without status migrainosus
G43.901	Migraine, unspecified, not intractable, with status migrainosus
G43.909	Migraine, unspecified, not intractable, without status migrainosus
G43.911	Migraine, unspecified, intractable, with status migrainosus
G43.919	Migraine, unspecified, intractable, without status migrainosus

REIMBURSEMENT INFORMATION:

Refer to section entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Part D: Florida Blue has delegated to Prime Therapeutics authority to make coverage determinations for the Medicare Part D services referenced in this guideline.

Medicare Advantage: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

DEFINITIONS:

None

RELATED GUIDELINES:

None

OTHER:

None

REFERENCES:

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Pharmacy Policy Committee on 06/12/24.

GUIDELINE UPDATE INFORMATION:

06/15/20	New Medical Coverage Guideline.
07/01/20	Revision: Added HCPCS code C9063
10/01/20	Revision: Added HCPCS code J3032 and removed codes C9063 and J3590.
10/15/20	Revision to position statement.
05/15/21	Revision to position statement.
07/15/23	Revision to position statement.
10/01/23	Revision to guideline; ICD10 codes
07/15/24	Review and revision to guideline; updated position statement and references.