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## What's New: 2/15/2025

New and Revised MCGs:	MCG Number	Update
1. <a href="#">Alpha1-Proteinase Inhibitors (Human)</a>	09-J0000-49	Review and revision to guideline; consisting of updating billing codes and references.
2. <a href="#">Ambulance Services</a>	09-A0000-01	Review: Position statements maintained.
3. <a href="#">Analysis of Human DNA as a Technique for Colorectal Cancer Screening</a>	05-82000-27	Review: Position statements maintained; reimbursement and references updated.
4. <a href="#">Asciminib (Scemblix) Tablet</a>	09-J4000-22	Review and revision to guideline consisting of updates to the description section (NCCN info), position statement, billing/coding section, and references. For previously untreated chronic-phase Ph+ CML, dasatinib is the preferred TKI. Added a new mutation, M244V, that is a contraindication for the use of Scemblix.
5. <a href="#">Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer</a>	05-86000-26	Review: Position statements maintained; description and references updated.
6. <a href="#">Bariatric Surgery</a>	02-40000-10	Scheduled review. Maintained position statement and updated references.

7. <a href="#">Benralizumab (Fasenra)</a>	09-J2000-92	Review of guideline; updated position statement and references.
8. <a href="#">Betibeglogene Autotemcel (Zynteglo) IV Infusion</a>	09-J4000-35	Review and revision to guidelines consisting of updating references.
9. <a href="#">Bosutinib (Bosulif) Capsules and Tablets</a>	09-J1000-84	Review and revision to guideline consisting of updates to the references.
10. <a href="#">Computed Tomographic (CT) Colonography (Virtual Colonoscopy)</a>	01-91000-06	Review; maintain position statements. Updated references.
11. <a href="#">Computed Tomographic Angiography (CTA) Heart</a>	04-70450-03	Review/revision. Added statement for automated quantification and characterization of coronary atherosclerotic plaque (0623T, 0624T, 0625T, 0626T). Updated references.
12. <a href="#">Dermabrasion, Chemical Peel, Salabrasion, and Acne Surgery</a>	02-10000-08	Review: Position statements maintained and references updated.
13. <a href="#">Drug Testing in Pain Management and Substance Use Disorder Treatment</a>	05-86000-32	Review: Position statements maintained; program exception section and references updated.
14. <a href="#">Facet Joint Injections</a>	02-61000-30	Scheduled review. Maintained position statement and updated references.
15. <a href="#">Growth Hormone Therapy</a>	09-J0000-27	Review and revision to guideline consisting of updating the position statement for HIV wasting and updated references.
16. <a href="#">Hip Arthroplasty</a>	02-20000-50	Scheduled review. Maintained position statement and updated references.
17. <a href="#">Hip Arthroscopy and Open, Non-Arthroplasty Hip Repair</a>	02-20000-55	Scheduled review. Revised description, maintained position statement and updated references.

18. <a href="#">Investigational Services</a>	09-A0000-03	Deleted code (0623T, 0624T, 0625T, 0626T) (refer to policy 04-70450-03).
19. <a href="#">Laboratory Tests Post Transplant and for Heart Failure</a>	05-86000-24	Review: Position statements maintained and references updated.
20. <a href="#">Lanreotide (Somatuline Depot) Injection</a>	09-J1000-20	Review and revision to guideline consisting of updating the dosing, warnings, and references.
21. <a href="#">Levoketoconazole (Recorlev) tablets</a>	09-J4000-17	Review and revision to guideline; consisting of updating the references.
22. <a href="#">Loncastuximab Tesirine-lpyl (Zynlonta)</a>	09-J4000-05	Review and revision to guideline consisting of updating references.
23. <a href="#">Mepolizumab (Nucala)</a>	09-J2000-54	Review and revision to guideline; update position statement and references.
24. <a href="#">Mohs Micrographic Surgery</a>	02-10000-03	Review: Position statements maintained and references updated.
25. <a href="#">Nilotinib (Tasigna) Capsules</a>	09-J1000-48	Review and revision to guideline consisting of updates to the references.
26. <a href="#">Octreotide Acetate (Sandostatin LAR Depot, Mycapssa Capsule)</a>	09-J0000-90	Review and revision to guideline; consisting of updating the dosing, warnings, and references.
27. <a href="#">Omalizumab (Xolair)</a>	09-J0000-44	Review and revision; consisting of updating position statement and references.
28. <a href="#">Osilodrostat (Isturisa)</a>	09-J3000-74	Review and revision to guideline; consisting of updating the references.
29. <a href="#">Parathyroid hormone (Natpara) injection</a>	09-J2000-39	Retired the guideline since the manufacturer discontinued Natpara in December 2024 with no plans to reintroduce it back to the market.

30. <a href="#"><u>Pasireotide (Signifor Signifor LAR) Injection</u></a>	09-J1000-94	Review and revision to guideline; consisting of updating the warnings and references.
31. <a href="#"><u>Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty</u></a>	02-20000-18	Scheduled review. Revise description. Maintain position statement and update references.
32. <a href="#"><u>Polatuzumab vedotin-piiq (Polivy) Infusion</u></a>	09-J3000-43	Review and revision to the guideline including updates to the description section, position statement, billing/coding, other section, and references. Per NCCN updates, follicular lymphoma removed as a covered indication. Removed the requirement that the member does not intend to proceed to a stem cell transplant. For the Pola-R-CHP regimen, broadened coverage to include several new indications. Polatuzumab + Lunsumio combination added for second-line or subsequent therapy for several indications.
33. <a href="#"><u>Reslizumab (Cinqair) IV infusion</u></a>	09-J2000-63	Review and revision; updated position statement, references.
34. <a href="#"><u>Ropeginterferon alfa-2b-njft (Besremi)</u></a>	09-J4000-19	Review and revision to guideline; including updating references.
35. <a href="#"><u>Teplizumab (Tzielid) Injection</u></a>	09-J4000-40	Review and revision to guideline consisting of updating the description, position statement, and references. Added requirements that pancreatic islet cell autoantibodies must be assessed in the past 6 months and on at least two separate occasions. A greater than or equal to 10% increase in HbA1c compared to baseline qualifies as dysglycemia. New Standards of Care in Diabetes - 2025 published.

36. <a href="#"><u>Tezepelumab-ekko (Tezspire)</u></a>	09-J4000-13	Review of guideline; updated position statement and references.
37. <a href="#"><u>Total Artificial Hearts and Implantable Ventricular Assist Devices</u></a>	02-33000-25	Scheduled review. Revised description, maintained position statement and updated references.
38. <a href="#"><u>Transcranial Magnetic Stimulation</u></a>	01-93875-18	Review; revised position statement. Updated references.
39. <a href="#"><u>Treatment of Tinnitus</u></a>	01-92502-11	Review; maintain position statements. Updated references.
40. <a href="#"><u>Tumor/Genetic Markers</u></a>	05-86000-22	Revision: Tumor-informed circulating tumor DNA testing for cancer management investigational statement added; references updated. Quarterly CPT/HCPCS update. Codes 0337U, 0338U, 0340U added; codes 0013U, 0014U, 0056U deleted.
41. <a href="#"><u>Valoctocogene roxaparvovec-rvox (Roctavian)</u></a>	09-J4000-62	Revision to guideline; updated position statement.
42. <a href="#"><u>Vagus Nerve Stimulation</u></a>	02-61000-22	Scheduled review. Revised description and position statement (added autoimmune disease to list of conditions considered E/I). Updated references.

Medical Coverage Guidelines (MCG) for the following oral oncology medications have been consolidated to a single MCG:

[09-J3000-65, Oral Oncology Medications](#)

A complete list of previous oral oncology MCGs that have been consolidated is shown below.

Generic/Brand	MCG Number	Generic/Brand	MCG Number
Abemaciclib (Verzenio)	09-J2000-93	Lenvatinib (Lenvima)	09-J2000-38
Acalabrutinib (Calquence)	09-J2000-94	Lorlatinib (Lorbrena)	09-J3000-23
Afatinib (Gilotrif)	09-J2000-06	Midostaurin (Rydapt)	09-J2000-86
Alectinib (Alecensa)	09-J2000-56	Neratinib (Nerlynx)	09-J2000-83
Alpelisib (Piqray)	09-J3000-42	Niraparib (Zejula)	09-J2000-77
Apalutamide (Erleada)	09-J3000-03	Olaparib (Lynparza)	09-J2000-32
Avapritinib (Ayvakit)	09-J3000-63	Osimertinib (Tagrisso)	09-J2000-55
Axitinib (Inlyta)	09-J1000-67	Palbociclib (Ibrance)	09-J2000-34
Binimetinib (Mektovi)	09-J3000-20	Panobinostat (Farydak)	09-J2000-37
Brigatinib (Alunbrig)	09-J2000-84	Pazopanib (Votrient)	09-J1000-49
Ceritinib (Zykadia)	09-J2000-17	Pexidartinib (Turalio)	09-J3000-47
Cobimetinib (Cotellic)	09-J2000-53	Pomalidomide (Pomalyst)	09-J1000-95
Crizotinib (Xalkori)	09-J1000-57	Ponatinib (Iclusig)	09-J1000-89
Dabrafenib (Tafinlar)	09-J2000-00	Regorafenib (Stivarga)	09-J1000-83
Dacomitinib (Vizimpro)	09-J3000-18	Rucaparib (Rubraca)	09-J2000-72
Darolutamide (Nubeqa)	09-J3000-50	Ruxolitinib (Jakafi)	09-J1000-63
Dasatinib (Sprycel)	09-J1000-43	Selinexor (Xpovio)	09-J3000-44
Duvelisib (Copiktra)	09-J3000-14	Sonidegib (Odomzo)	09-J2000-45
Enasidenib (Idhifa)	09-J2000-90	Sorafenib (Nexavar)	09-J1000-50
Encorafenib (Braftovi)	09-J3000-19	Sunitinib Malate (Sutent)	09-J1000-51
Entrectinib (Rozlytrek)	09-J3000-48	Talazoparib (Talzenna)	09-J3000-21
Enzalutamide (Xtandi)	09-J1000-85	Topotecan HCl (Hycamtin)	09-J1000-02
Erdafitinib (Balversa)	09-J3000-31	Trametinib (Mekinist)	09-J1000-99
Gefitinib (Iressa)	09-J2000-44	Tretinoin Oral	09-J1000-61
Gilteritinib (Xospata)	09-J3000-28	Trifluridine-Tipiracil (Lonsurf)	09-J2000-46
Glasdegib (Daurismo)	09-J3000-27	Vandetanib (Caprelsa)	09-J1000-38
Idelalisib (Zydelig)	09-J2000-23	Vemurafenib (Zelboraf)	09-J1000-40
Ivosidenib (Tibsovo)	09-J3000-13	Venetoclax (Venclexta)	09-J2000-64
Lapatinib (Tykerb)	09-J1000-47	Vismodegib (Erivedge)	09-J1000-66

Larotrectinib (Vitrakvi)

09-J3000-25

Vorinostat (Zolinza)

09-J1000-54

Lenalidomide (Revlimid)

09-J0000-80

Zanubrutinib (Brukinsa)

09-J3000-62

The prior Medical Coverage Guideline (MCG) for this therapy has been consolidated to a single MCG:

[09-J3000-93, Exon-Skipping Therapy for Duchenne Muscular Dystrophy](#)

A complete list of previous MCGs that have been consolidated is shown below.

Generic/Brand	MCG Number
Eteplirsen (Exondys 51)	09-J2000-69
Golodirsen (Vyondys 53)	09-J3000-55
Viltolarsen (Viltepso)	09-J3000-78



## Medical Coverage Guideline: 09-J2000-91, Tisagenlecleucel (Kymriah) Infusion

The prior Medical Coverage Guideline (MCG) for this therapy has been consolidated to a single MCG:

[09-J3000-94, Chimeric Antigen Receptor \(CAR\) T-Cell Therapies](#)

A complete list of previous CAR T-cell therapy MCGs that have been consolidated is shown below.

Generic/Brand	MCG Number
Tisagenlecleucel (Kymriah) Infusion	09-J2000-91
Axicabtagene Ciloleucel (Yescarta) Infusion	09-J2000-95
Brexucabtagene Autoleucel (Tecartus) Infusion	09-J3000-71
Lisocabtagene Maraleucel (Breyanzi)	09-J3000-83

## **Policy Review Information**

Submit new information relevant to a policy when next reviewed by Florida Blue to:

### **Florida Blue Medical Policy Area**

**4800 Deerwood Campus Parkway**

**Building 900, 5th floor**

**Jacksonville, FL 32246-8273**

## Preventive Services Information

Preventive services include a broad range of services (including screening tests, counseling, and immunizations/vaccines). Florida Blue has adopted the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services: [childhood and adolescent immunization schedule approved by: the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP); adult immunization schedule approved by: the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP)].

[Centers for Disease Control and Prevention \(CDC\)](#) (recommended vaccines and immunizations).

[Guide to Clinical Preventive Services](#) (recommendations made by the **USPSTF** for clinical preventive services).

# Medicare Part B Pharmacy Review Updates

Effective January 1, 2024, the following updates to the Medical Coverage Guideline Program Exceptions will go into effect:

## Program Exceptions:

### Medicare Advantage Products (Effective 1/1/2024):

For treatment initiation and continuing therapy under Medicare Advantage:

1. Approve for one (1) year unless a shorter duration is clinically indicated under FDA label (Dosage and Administration section).
2. Approve per duration indicated in the associated Florida Blue Medical Coverage Guideline (MCG) if MCG approval duration exceeds FDA label for clinical evaluation.

In the absence of dosing frequency information within the Local Coverage Determination (LCD) or National Coverage Determination (NCD), refer to the Position Statement section or Dosage and Administration section within the associated Medical Coverage Guideline.