United Healthcare Community Plan

UnitedHealthcare Community Plan of Ohio
Medical Policy Update Bulletin: December 2023

Access a policy listed below for complete details on the latest updates. A comprehensive summary of changes is provided at the bottom of every policy document for your reference. To view a detailed version of this bulletin, click here.

Medical Policy Updates

Policy Title	Status	Effective Date
Genetic Testing for Neuromuscular Disorders (for Ohio Only)	Revised	Jan. 1, 2024
Hepatitis Screening (for Ohio Only)	Updated	Jan. 1, 2024
Hysterectomy (for Ohio Only)	Updated	Jan. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
17-Alpha-Hydroxyprogesterone Caproate (Makena® and 17P) (for Ohio Only)	Revised	Jan. 1, 2024
Actemra® (Tocilizumab) Injection for Intravenous Infusion (for Ohio Only)	Revised	Jan. 1, 2024
Alpha$_1$-Proteinase Inhibitors (for Ohio Only)	Revised	Jan. 1, 2024
Benlysta® (Belimumab) (for Ohio Only)	Revised	Jan. 1, 2024
Botulinum Toxins A and B (for Ohio Only)	Revised	Jan. 1, 2024
Brineura® (Cerliponase Alfa) (for Ohio Only)	Updated	Jan. 1, 2024
Briumvi® (Ublituximab-Xiiy) (for Ohio Only)	New	Jan. 1, 2024
Cimzia® (Certolizumab Pegol) (for Ohio Only)	Revised	Jan. 1, 2024
Complement Inhibitors (Soliris® & Ultomiris®) (for Ohio Only)	Revised	Jan. 1, 2024
Crysvita® (Burosumab-Twza) (for Ohio Only)	Revised	Jan. 1, 2024
Denosumab (Prolia® & Xgeva®) (for Ohio Only)	Revised	Jan. 1, 2024
Enjaymo® (Sutimlimab-Jome) (for Ohio Only)	Updated	Jan. 1, 2024
Entyvio® (Vedolizumab) (for Ohio Only)	Revised	Jan. 1, 2024
Erythropoiesis-Stimulating Agents (for Ohio Only)	Revised	Jan. 1, 2024
Evkeeza® (Evinacumab-Dgnb) (for Ohio Only)	Revised	Jan. 1, 2024
Givlaari® (Givosiran) (for Ohio Only)	Updated	Jan. 1, 2024
Gonadotropin Releasing Hormone Analogs (for Ohio Only)	Revised	Jan. 1, 2024
Hereditary Angioedema (HAE), Treatment and Prophylaxis (for Ohio Only)	Updated	Jan. 1, 2024
Ilumya® (Tildrakizumab-Asmn) (for Ohio Only)	Revised	Jan. 1, 2024
Immune Globulin (IVIG and SCIG) (for Ohio Only)	Revised	Jan. 1, 2024
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (for Ohio Only)	Revised	Jan. 1, 2024
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease (for Ohio Only)	Revised	Jan. 1, 2024
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®) (for Ohio Only)	Revised	Jan. 1, 2024

Policy Title	Status	Effective Date
Intravitreal Corticosteroid Implants (for Ohio Only)	Updated	Jan. 1, 2024
Korsuva® (Difelikefalin) (for Ohio Only)	Updated	Jan. 1, 2024
Lemtrada (Alemtuzumab) (for Ohio Only)	Revised	Jan. 1, 2024
Leqvio® (Inclisiran) (for Ohio Only)	Revised	Jan. 1, 2024
Long-Acting Injectable Antiretroviral Agents for HIV (for Ohio Only)	Revised	Jan. 1, 2024
Luxturna® (Voretigene Neparvovec-Rzyl) (for Ohio Only)	Revised	Jan. 1, 2024
Maximum Dosage and Frequency (for Ohio Only)	Revised	Jan. 1, 2024
Medical Therapies for Enzyme Deficiencies (for Ohio Only)	Revised	Jan. 1, 2024
Nplate® (Romiplostim) (for Ohio Only)	Revised	Jan. 1, 2024
Ocrevus® (Ocrelizumab) (for Ohio Only)	Revised	Jan. 1, 2024
Off-Label/Unproven Specialty Drug Treatment (for Ohio Only)	Updated	Jan. 1, 2024
Oncology Medication Clinical Coverage (for Ohio Only)	Revised	Jan. 1, 2024
Ophthalmologic Complement Inhibitors (for Ohio Only)	New	Jan. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors (for Ohio Only)	Revised	Jan. 1, 2024
Orencia® (Abatacept) Injection for Intravenous Infusion (for Ohio Only)	Revised	Jan. 1, 2024
Oxlumo® (Lumasiran) (for Ohio Only)	Updated	Jan. 1, 2024
Provider Administered Drugs – Site of Care (for Ohio Only)	Revised	Jan. 1, 2024
Qalsody® (Tofersen) (for Ohio Only)	New	Jan. 1, 2024
Radicava® (Edaravone) (for Ohio Only)	Updated	Jan. 1, 2024
Rebyota™ (Fecal Microbiota, Live-Jslm) (for Ohio Only)	New	Jan. 1, 2024
Repository Corticotropin Injections (for Ohio Only)	Revised	Jan. 1, 2024
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®) (for Ohio Only)	Revised	Jan. 1, 2024
Rituximab (Riabni®, Rituxan®, Ruxience®, & Truxima®) (for Ohio Only)	Revised	Jan. 1, 2024
RNA-Targeted Therapies (Amvuttra® and Onpattro®) (for Ohio Only)	Revised	Jan. 1, 2024
Ryplazim® (Plasminogen, Human-Tvmh) (for Ohio Only)	Updated	Jan. 1, 2024
Scenesse® (Afamelanotide) (for Ohio Only)	Revised	Jan. 1, 2024
Simponi Aria® (Golimumab) Injection for Intravenous Infusion (for Ohio Only)	Revised	Jan. 1, 2024
Sodium Hyaluronate (for Ohio Only)	Revised	Jan. 1, 2024
Somatostatin Analogs (for Ohio Only)	Revised	Jan. 1, 2024
Spevigo® (Spesolimab-Sbzo) (for Ohio Only)	New	Jan. 1, 2024
Spinraza® (Nusinersen) (for Ohio Only)	Revised	Jan. 1, 2024
Stelara® (Ustekinumab) (for Ohio Only)	Revised	Jan. 1, 2024
Synagis® (Palivizumab) (for Ohio Only)	Revised	Jan. 1, 2024
Tezspire® (Tezepelumab-Ekko) (for Ohio Only)	Revised	Jan. 1, 2024
Trogarzo® (Ibalizumab-Uiyk) (for Ohio Only)	Revised	Jan. 1, 2024
Tysabri® (Natalizumab) (for Ohio Only)	Revised	Jan. 1, 2024
Uplizna® (Inebilizumab-Cdon) (for Ohio Only)	Revised	Jan. 1, 2024
Viltepso® (Viltolarsen) (for Ohio Only)	Updated	Jan. 1, 2024
Vyepti® (Eptinezumab-Jjmr) (for Ohio Only)	Revised	Jan. 1, 2024
Vyjuvek™ (Beramagene Geperpavec-Svdt) (for Ohio Only)	New	Jan. 1, 2024
White Blood Cell Colony Stimulating Factors (for Ohio Only)	Revised	Jan. 1, 2024
Xolair® (Omalizumab) (for Ohio Only)	Revised	Jan. 1, 2024

General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced, or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Community Plan of Indiana Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline, and Utilization Review Guideline updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New clinical coverage criteria have been adopted for a health service (e.g., test, drug, device, or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

The complete library of Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines for UnitedHealthcare Community Plan of Ohio is available at **UHCprovider.com/OH** > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Ohio Medical & Drug Policies and Coverage Determination Guidelines.