secukinumab (Cosentyx™) intravenous

Medicare Advantage Medical Policy #MA-223
Original Effective Date: 09/01/2026
Current Effective Date: 09/01/2026

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Blue Advantage does not cover investigational or experimental services, including any drug, device, procedure, or service provided under the investigational arm of a clinical trial or study unless mandated by the Centers for Medicare and Medicaid Services. Coverage is limited to routine services for Category A IDE studies and to devices and related services for Category B IDE studies when not supplied by the trial sponsor. Approved IDE studies are posted on www.cms.gov/medicare/coverage/evidence.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Per the Self-Administered Drug list as defined by the Medicare Administrative Contractor for the Health Plan, subcutaneous secukinumab (Cosentyx™)‡ is eligible for coverage under Part D only and not targeted by this policy.

Psoriatic Arthritis

Based on review of available data, the Health Plan may consider secukinumab (Cosentyx™)‡ for the treatment of patients with active psoriatic arthritis to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility for secukinumab (Cosentyx) will be considered when ALL of the following criteria are met:

Initial

- Patient has a diagnosis of active psoriatic arthritis; AND
- Patient has a negative TB test (e.g. PPD, blood test) prior to treatment; AND
- Cosentyx is NOT used in combination with other biologic DMARDs, such as adalimumab (Humira, biosimilars) or Enbrel, OR other drugs, such as Otezla or Xeljanz/XR; AND
- Patient has failed treatment with one or more traditional DMARDs, such as methotrexate, unless there is clinical evidence or patient history that suggests the use of these products will be ineffective or cause an adverse reaction to the patient.; AND
- Patient is 18 years of age or older; AND
- ONE of the following dosing regimens will be used:
    - WITH a loading dose: 6 mg/kg at Week 0, followed by 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion thereafter; OR
    - WITHOUT a loading dose: 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion.

Continuation

- Patient has received an initial authorization for Cosentyx from the plan OR has provided documentation of authorization for an active course of treatment from previous health plan; AND
- Patient has received at least 6 months of therapy with the requested drug; AND
- Cosentyx is NOT used in combination with other biologic disease-modifying anti-rheumatic drugs (DMARDs), such as adalimumab (Humira, biosimilars) or Enbrel, OR other drugs, such as Otezla or Xeljanz/XR; AND
- Patient has received a beneficial clinical response from baseline (prior to initiating Cosentyx) as evidenced by at least ONE of the following:
    - Improvement evidenced by an objective measure (for example, Disease Activity Index for Psoriatic Arthritis [DAPSA], Composite Psoriatic Disease Activity Index [CPDAI], Psoriatic Arthritis Disease Activity Score [PsA DAS], serum markers); OR
    - Less joint pain; OR
    - Decreased morning stiffness or fatigue; OR
    - Improved function or activities of daily living; OR
    - Decreased soft tissue swelling in joints or tendon sheaths; AND
    - The requested dose is 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion.

Ankylosing Spondylitis

Based on review of available data, the Health Plan may consider secukinumab (Cosentyx) for the treatment of patients with active ankylosing spondylitis to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility for secukinumab (Cosentyx) will be considered when ALL of the following criteria are met:

Initial

- Patient has a diagnosis of active ankylosing spondylitis; AND
- Patient is 18 years of age or older; AND
- Patient has a negative TB test (e.g. PPD, blood test) prior to treatment; AND
- Cosentyx is NOT used in combination with other biologic DMARDs, such as adalimumab (Humira, biosimilars) or Enbrel, OR other drugs, such as Otezla or Xeljanz/XR; AND
- Patient has failed treatment with non-steroidal anti-inflammatory drugs (NSAIDs), such as naproxen, or has documented contraindications to NSAIDs usage; AND
- ONE of the following dosing regimens will be used:
    - WITH a loading dose: 6 mg/kg at Week 0, followed by 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion thereafter; OR
    - WITHOUT a loading dose: 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion.

Continuation

- Patient has received an initial authorization for Cosentyx from the plan OR has provided documentation of authorization for an active course of treatment from previous health plan; AND
- Patient has received at least 6 months of therapy with the requested drug; AND
- Cosentyx is NOT used in combination with other biologic disease-modifying anti-rheumatic drugs (DMARDs), such as adalimumab (Humira, biosimilars) or Enbrel, OR other drugs, such as Otezla or Xeljanz/XR; AND
- Patient has received a beneficial clinical response from baseline (prior to initiating Cosentyx) as evidenced by at least ONE of the following:
    - Improvement evidenced by an objective measure (for example, Ankylosing Spondylitis Disease Activity Score, Ankylosing Spondylitis Quality of Life Scale [ASQoL], Health Assessment Questionnaire for the Spondyloarthropathies [HAQ-S], serum markers); OR
    - Decreased pain or stiffness; OR
    - Improvement in function or activities of daily living; AND
- The requested dose is 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion.

Non-Radiographic Axial Spondyloarthritis

Based on review of available data, the Health Plan may consider the use of secukinumab (Cosentyx) for the treatment of patients with non-radiographic axial spondyloarthritis to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility for secukinumab (Cosentyx) will be considered when ALL of the following criteria are met:

Initial

- Patient has active non-radiographic axial spondyloarthritis as confirmed by the presence of sacroiliitis on magnetic resonance imaging (MRI); AND
- Patient has failed at least TWO months of current continuous therapy with at least TWO different oral NSAIDs (at prescription strength dosages) unless there is clinical evidence or patient history that suggests these products will be ineffective or cause an adverse reaction to the patient; AND
- Patient is 18 years of age or older; AND
- Cosentyx is NOT used in combination with other biologic DMARDs, such as adalimumab (Humira, biosimilars) or Enbrel, OR other drugs, such as Otezla or Xeljanz/XR; AND
- Patient has a negative TB test (e.g., PPD, blood test) prior to treatment; AND
- ONE of the following dosing regimens will be used:
    - WITH a loading dose: 6 mg/kg at Week 0, followed by 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion thereafter; OR

- WITHOUT a loading dose: 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion.

Continuation

- Patient has received an initial authorization for Cosentyx from the plan OR has provided documentation of authorization for an active course of treatment from previous health plan; AND
- Patient has received at least 6 months of therapy with the requested drug; AND
- Cosentyx is NOT used in combination with other biologic disease-modifying anti-rheumatic drugs (DMARDs), such as adalimumab (Humira, biosimilars) or Enbrel, OR other drugs, such as Otezla or Xeljanz/XR; AND
- Patient has received a beneficial clinical response from baseline (prior to initiating Cosentyx) as evidenced by at least ONE of the following:
  - Improvement evidenced by an objective measure (for example, Ankylosing Spondylitis Disease Activity Score [ASDAS], Ankylosing Spondylitis Quality of Life Scale [ASQoL], Bath Ankylosing Spondylitis Disease Activity Index [BASDAI], Bath Ankylosing Spondylitis Functional Index [BASFI], serum markers); OR
  - Decreased pain or stiffness; OR
  - Improvement in function or activities of daily living; AND
- The requested dose is 1.75 mg/kg every 4 weeks not exceeding the maximum maintenance dose of 300 mg per infusion.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Health Plan considers the use of secukinumab (Cosentyx) when any of the following criteria for their respective disease listed below (and denoted in the patient selection criteria above) are not met to be **not medically necessary**:**

- For psoriatic arthritis:
  - Patient has failed treatment with one or more traditional DMARDs
  - For continuation requests: Patient has received at least 6 months of therapy with the requested drug
  - For continuation requests: Patient has received a beneficial clinical response from baseline (prior to initiating Cosentyx) as evidenced by at least ONE of the following:
    - Improvement evidenced by an objective measure (for example, Disease Activity Index for Psoriatic Arthritis [DAPSA], Composite Psoriatic Disease Activity Index [CPDAI], Psoriatic Arthritis Disease Activity Score [PsA DAS], serum markers); OR
    - Less joint pain; OR
    - Decreased morning stiffness or fatigue; OR
    - Improved function or activities of daily living; OR
    - Decreased soft tissue swelling in joints or tendon sheaths
- For ankylosing spondylitis:

- Patient has failed treatment with NSAIDs
- For continuation requests: Patient has received at least 6 months of therapy with the requested drug
- For continuation requests: Patient has received a beneficial clinical response from baseline (prior to initiating Cosentyx) as evidenced by at least ONE of the following:
  - Improvement evidenced by an objective measure (for example, Ankylosing Spondylitis Disease Activity Score, Ankylosing Spondylitis Quality of Life Scale [ASQoL], Health Assessment Questionnaire for the Spondyloarthropathies [HAQ-S], serum markers); OR
  - Decreased pain or stiffness; OR
  - Improvement in function or activities of daily living

- For active non-radiographic axial spondyloarthritis:
  - Patient has failed at least TWO months of current continuous therapy with at least TWO different oral NSAIDs (at prescription strength dosages)
  - For continuation requests: Patient has received at least 6 months of therapy with the requested drug
  - For continuation requests: Patient has received a beneficial clinical response from baseline (prior to initiating Cosentyx) as evidenced by at least ONE of the following:
    - Improvement evidenced by an objective measure (for example, Ankylosing Spondylitis Disease Activity Score [ASDAS], Ankylosing Spondylitis Quality of Life Scale [ASQoL], Bath Ankylosing Spondylitis Disease Activity Index [BASDAI], Bath Ankylosing Spondylitis Functional Index [BASFI], serum markers); OR
    - Decreased pain or stiffness; OR
    - Improvement in function or activities of daily living

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Health Plan considers the use of secukinumab (Cosentyx) when patient selection criteria are not met to be **investigational*** (with the exception of those denoted above as **not medically necessary**).**

Based on review of available data, the Health Plan considers the use of secukinumab (Cosentyx) for indications other than those listed above to be **investigational.***

Background/Overview

Cosentyx is a human interleukin (IL)-17A antagonist indicated in patients 6 years and older with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy, patients 2 years of age and older with active psoriatic arthritis, adults with active ankylosing

spondylitis, adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation, active enthesitis-related arthritis in patients 4 years of age and older, and adults with moderate to severe hidradenitis suppurativa. IL-17A is a naturally occurring cytokine that is involved in normal inflammatory and immune responses. Cosentyx inhibits the release of pro-inflammatory cytokines and chemokines. Cosentyx is available in 150 mg dosages supplied as pens and prefilled syringes for subcutaneous injection as well as 300 mg dosages supplied as pens and prefilled syringes for subcutaneous injection. Cosentyx is also available as a 125 mg vial for intravenous infusion. Cosentyx for intravenous infusion may only be administered in adults with psoriatic arthritis, adults with ankylosing spondyloarthritis, and adults with non-radiographic axial spondyloarthritis. For pediatric patients, there is a 75 mg prefilled syringe available. Dosing information can be found in the package insert.

Psoriatic Arthritis
Psoriatic arthritis is an arthritis that is often associated with psoriasis of the skin. Typically, first line treatments such as DMARDs (disease modifying anti-rheumatic drugs) are used to treat this condition. An example of a DMARD would include methotrexate.

Ankylosing Spondylitis
Ankylosing spondylitis is a chronic inflammatory disease that affects the joints between the vertebrae of the spine, and the joints between the spine and the pelvis. It eventually causes the affected vertebrae to fuse or grow together. Nonsteroidal anti-inflammatory drugs such as ibuprofen or naproxen are used to reduce inflammation and pain associated with the condition. Corticosteroid therapy or medications to suppress the immune system may be prescribed to control various symptoms.

Disease-Modifying Anti-Rheumatic Drugs (DMARDs)
Disease-modifying anti-rheumatic drugs are typically used for the treatment of inflammatory conditions. These drugs slow the disease process by modifying the immune system.

- methotrexate
- cyclosporine
- sulfasalazine
- mercaptopurine
- gold compounds

Non-Radiographic Axial Spondyloarthritis.
Axial spondyloarthritis is an inflammatory arthritis of the spine. It often presents as chronic back pain, typically before the age of 45 and is often associated with one or more articular features (e.g., synovitis, enthesitis, and dactylitis) and/or non-articular features (e.g., uveitis, psoriasis, and inflammatory bowel diseases). Patients with this condition are classified as having one of two types of axial spondyloarthritis: either radiographic or non-radiographic. As supported by the name, the non-radiographic variety isn't evident on plain radiography and instead the diagnosis is supported by evidence of active inflammation of the sacroiliac joints via magnetic resonance imaging (MRI).

Traditional pharmacologic therapy for the treatment of non-radiographic axial spondyloarthritis includes oral NSAIDs. Approximately 70-80% of patients with this condition report substantial relief with NSAID therapy. The effect of an NSAID is typically seen within two to four weeks and multiple NSAIDs need to be tried as patient response to a particular NSAID isn't predictable. Currently, Cimzia®‡ is the only TNF inhibitor product that is approved for non-radiographic axial spondyloarthritis. Most recently, Taltz®‡ and Cosentyx, both interleukin blockers, have gained approval for this indication. Rinvoq®‡, a janus kinase inhibitor, has this indication as well. If a response to two NSAIDs has not proven beneficial, a tumor necrosis factor (TNF) alpha inhibitor, such as Cimzia, or an interleukin blocker, such as Taltz or Cosentyx, would be the next treatment option. Rinvoq is typically used after failure of a TNF inhibitor.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Cosentyx was approved by the FDA in January of 2015 for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy. In January of 2016, Cosentyx gained additional indications for active psoriatic arthritis and active ankylosing spondylitis. In June of 2020, Cosentyx was granted FDA approval for adults with active non-radiographic axial spondyloarthritis. In May of 2021, the plaque psoriasis indication was expanded from 18 years of age and older to 6 years of age and older. In December of 2021, the age for active psoriatic arthritis was changed from 18 years of age to 2 years of age and older. At the same time, Cosentyx was granted FDA approval for the treatment of active enthesitis-related arthritis in patients 4 years of age and older. In 2023, Cosentyx received FDA approval for moderate to severe hidradenitis suppurativa in adults.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Adult Psoriatic Arthritis Studies

The safety and efficacy of Cosentyx were assessed in 1,003 patients in 2 randomized, double-blind, placebo-controlled trials in adult patients, age 18 years and older with active psoriatic arthritis. Study 1 for psoriatic arthritis evaluated 397 patients who were treated with Cosentyx 75 mg, 150 mg, or 300 mg at weeks 0, 1, 2, 3, and 4, followed by the same dose every 4 weeks. Patients receiving placebo were re-randomized to receive Cosentyx (either 150 mg or 300 mg every 4 weeks) at week 16 or week 24 based on responder status. The primary endpoint was the percentage of patients achieving a 20% improvement in the American College of Radiology score (ACR20) at week 24. In this study, patients treated with 150 mg or 300 mg of Cosentyx demonstrated a greater clinical response including ACR20, ACR50, and ACR70 compared to placebo at week 24. The percentage

of patients achieving ACR20 at week 24 was 51% in the Cosentyx 150 mg group, 54% in the Cosentyx 300 mg group, and 15% in the placebo group. Results of the second study were not included in the package insert due to an intravenous loading dose being used (which is not approved in the United States).

Ankylosing Spondylitis Studies
The safety and efficacy of Cosentyx were assessed in 590 patients in two randomized, double-blind, placebo-controlled studies in adult patients 18 years of age and older with active ankylosing spondylitis. The first study for ankylosing spondylitis evaluated 219 patients who were treated with Cosentyx 75 mg or 150 mg at weeks 0, 1, 2, 3, and 4, followed by the same dose every 4 weeks. At week 16, patients receiving placebo were re-randomized to either Cosentyx 75 mg or 150 mg every 4 weeks. The primary endpoint was the percentage of patients achieving a 20 percent improvement in the Ankylosing Spondylitis Disease Activity Score (ASAS20) response at week 16. In this study, patients treated with 150 mg of Cosentyx demonstrated greater improvements in ASAS20 and ASAS40 responses compared to placebo at week 16. At week 16, 61% of patients taking Cosentyx 150 mg achieved ASAS20 vs. 28% taking placebo. Results of the second study were not included in the package insert due to an intravenous loading dose being used (which is not approved in the United States).

Non-Radiographic Axial Spondyloarthritis
The safety and efficacy of Cosentyx were assessed in 555 patients in one randomized, double-blind, placebo-controlled study in adult patients 18 years of age and older with active non-radiographic axial spondyloarthritis. Patients were treated with Cosentyx 150 mg with a loading dose (weeks 0, 1, 2, 3, and 4) or without a loading dose (weeks 0 and 4) followed by the same dose every 4 weeks or placebo. In the double-blind period, patients (n=555) received either placebo or Cosentyx for 52 weeks. Starting week 16, dose adjustment or addition of concomitant NSAIDs and DMARDs was permitted. Starting at week 20, patients were allowed to switch to open-label Cosentyx 150 mg monthly or other biologic at the discretion of the investigator and patient. The primary endpoint was at least a 40% improvement in Assessment of Spondyloarthritis International Society (ASAS40) at week 52. At week 52, the Cosentyx without a loading dose group had 38% of subjects achieving the primary endpoint versus 34% in the Cosentyx with a loading dose group versus 19% of subjects in the placebo group.

References

1. Cosentyx [package insert]. Novartis Pharmaceuticals Corporation. East Hanover, New Jersey. Updated April 2026.
2. Cosentyx Drug Evaluation. Express Scripts. January 2015

Policy History

Original Effective Date: 09/01/2026
Current Effective Date: 09/01/2026

secukinumab (Cosentyx™) intravenous

Medicare Advantage Medical Policy #MA-223
Original Effective Date: 09/01/2026
Current Effective Date: 09/01/2026

06/16/2026 UM Committee review and approval. New policy.
Next Scheduled Review Date: 06/2027

Coding

The five character codes included in the Health Plan Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of the Health Plan Medical Policy Coverage Guidelines is with the Health Plan and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the Health Plan Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of the Health Plan Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	No codes
HCPCS	J3247
ICD-10 Diagnosis	All Related Diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or

diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. Consultation with technology evaluation center(s);
2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan's Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: All codes listed on the Medical Policy require prior authorization. This ensures appropriate utilization and alignment with current clinical guidelines.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Blue Advantage), Blue Advantage may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Blue Advantage health plan.

Medicare Advantage Members
Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-bene-help.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.