STEP THERAPY POLICY

POLICY: Diuretics – Loop Products Step Therapy Policy
- bumetanide tablets (generic only)
- Edecrin® (ethacrynic acid tablets – Bausch/Patheon, generic)
- Furoscix® (furosemide subcutaneous injection by on-body infusor – scPharmaceuticals)
- Lasix® (furosemide tablets – Validus, generic)
- Soaanz® (torsemide tablets – Sarfez)
- torsemide tablets (generic only)

REVIEW DATE: 06/18/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

The medications included in this policy are loop diuretics. For most products, the indications for use are very similar and are noted below.

Bumetanide tablets (generic) are indicated for:[1]
- Treatment of **edema** associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome.

Ethacrynic acid tablets are indicated for:[2]

- Treatment of **edema** associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. It is also indicated for **short-term management of ascites** due to malignancy, idiopathic edema, and lymphedema and **short-term management of congenital heart disease or nephrotic syndrome** in pediatric patients, other than infants.

Furosemide tablets are indicated for:[3]
- Treatment of **edema** associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome, in adults and pediatric patients.
- Treatment of **hypertension**, alone or in combination with other antihypertensive agents, in adults.

Furoscix is indicated for:[4]
- Treatment of **edema** in adults with chronic heart failure or chronic kidney disease, including the nephrotic syndrome.

Soaanz is indicated for:[5]
- Treatment of **edema** associated with heart failure or renal disease in adults.

Torsemide tablets (generic) are indicated for:[6]
- Treatment of **edema** associated with heart failure, renal disease or hepatic disease.
- Treatment of **hypertension**, to lower blood pressure.

POLICY STATEMENT

This program has been developed to encourage the use of a Step 1 Product prior to the use of a Step 2 Product. If the Step Therapy rule is not met for a Step 2 Product at the point of service, coverage will be determined by the Step Therapy criteria below. All approvals are provided for 1 year in duration.

Step 1: bumetanide tablets, ethacrynic acid tablets, furosemide tablets, torsemide tablets

Step 2: Edecrin tablets, Lasix tablets, Soaanz tablets, Furoscix

Diuretics – Loop Products Step Therapy Policy **product(s) is(are) covered as medically necessary when the following step therapy criteria is(are) met. Any other exception is considered not medically necessary.**

CRITERIA

1. If the patient has tried one Step 1 Product, approve a Step 2 Product.

REFERENCES

1. Bumex® tablets [prescribing information]. Parsippany, NJ: Validus; January 2024.
2. Edecrin® tablets and Sodium Edecrin® intravenous solution [prescribing information]. Bridgewater, NJ and Greenville, NC; Bausch and Patheon; August 2020.
3. Lasix® tablets [prescribing information]. Parsippany, NJ: Validus; August 2018.
4. Furoscix® subcutaneous injection by on-body infusor [prescribing information]. Burlington, MA: scPharmaceuticals; March 2025.
5. Soaanz® tablets [prescribing information]. Vienna, VA: Sarfex; November 2021.
6. Demadex® tablets [prescribing information]. Somerset, NJ: Meda; February 2017.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	06/14/2023
Annual Revision	No criteria changes.	06/26/2024
Annual Revision	No criteria changes.	06/18/2025