PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMENDEMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Paliperidone Palmitate (e.g., Long-acting Injectables Invega Sustenna & Invega Trinza, Erzofri)	2016021	Coverage criteria updated for monthly and 3-month formulation. Added criteria for 6-month formulation. Add authorization renewal criteria for all formulations. Long-acting injectable paliperidone palmitate (e.g., Invega Sustenna, Erzofri) as a monthly formulation INITIAL APPROVAL 1. Individual has a diagnosis of one of the following: a. Schizophrenia; OR b. Schizoaffective disorder; AND 2. Individual is at least 18 years of age; AND 3. Schizophrenia or schizoaffective disorder diagnosed by psychiatric specialist; AND 4. Invega Sustenna/ Erzofri to be prescribed by or in consultation with a psychiatrist; AND 5. Individual does not have dementia-related psychosis; AND 6. Individual has demonstrated tolerability to oral paliperidone or oral risperidone. AUTHORIZATION RENEWAL 1. Manageable or no side effects; AND 2. Condition stable or improved. Long-acting injectable paliperidone palmitate (e.g., Invega Trinza) as a 3-month formulation INITIAL APPROVAL 1. Individual has a diagnosis of schizophrenia; AND 2. Individual is at least 18 years of age; AND 3. Schizophrenia diagnosed by psychiatric specialist; AND 4. Medication to be prescribed by or in consultation with a psychiatrist; AND 5. Individual does not have dementia-related psychosis; AND	No	November 11, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2016021

		6. Individual has been treated with Invega Sustenna (monthly paliperidone palmitate injection) for at least 4 months AND last two doses of Invega Sustenna were same dosage strength. AUTHORIZATION RENEWAL 1. Condition improved with treatment; AND 2. Manageable or no side effects. Long-acting injectable paliperidone palmitate (e.g., Invega Hafyera) as a <u>6-month</u> formulation INITIAL APPROVAL 1. Individual has a diagnosis of schizophrenia; AND 2. Individual is at least 18 years of age; AND 3. Schizophrenia diagnosed by psychiatric specialist; AND 4. Medication to be prescribed by or in consultation with a psychiatrist; AND 5. Individual does not have dementia-related psychosis; AND 6. Individual has been treated with Invega Sustenna (monthly paliperidone palmitate injection) for at least 4 months AND last two doses of Invega Sustenna were same dosage strength; OR 7. Individual has been treated with Invega Trinza for at least 3 months. AUTHORIZATION RENEWAL 1. Condition improved with treatment; AND 2. Manageable or no side effects.			
Teplizumab-mzwv (e.g., Tzield)	2023012	Coverage updated to the newest FDA-approved label. <u>STAGE 2 TYPE 1 DIABETES</u> 1. The Individual is 1 year of age or older; AND 2. The individual does not have a clinical diagnosis of Type 1 diabetes (i.e., stage 3); AND	No	November 11, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023012

		3. Documentation is provided that the individual has stage 2 type 1 diabetes confirmed by: a. The presence of two or more of the following pancreatic islet cell autoantibodies: i. Glutamic acid decarboxylase 65 (GAD) autoantibodies; ii. Insulin autoantibody (IAA); iii. Insulinoma-associated antigen 2 autoantibody (IA-2A); iv. Zinc transporter 8 autoantibody (ZnT8A); v. Islet cell autoantibody (ICA); AND b. Dysglycemia on an oral glucose-tolerance test (or alternative glycemic test if an oral glucose-tolerance test is not available): i. Fasting blood glucose greater than 110 mg/dL and less than 126 mg/dL; OR ii. 2-hour post prandial plasma glucose level greater than or equal to 140 mg/dL and less than 200 mg/dL; OR iii. Hgb A1C 5.7-6.4 (Insel, 2015); AND 4. The individual does not have evidence of ANY of the following: a. Lymphocyte count less than or equal to 1,000 lymphocytes/mcL; OR b. Platelet count less than or equal to 150,000 platelets/mcL; OR c. Elevated ALT or AST greater than 2 times the upper limit of normal (ULN) or bilirubin greater than 1.5 times ULN; OR d. Laboratory or clinical evidence of acute infection with Epstein-Barr			

		virus (FBV) or cytomegalovirus (CMV); OR e. Active serious infection or chronic active infection other than localized skin infections; AND 5. Clinical history of individual does not suggest type 2 diabetes or non-autoimmune dysglycemic conditions.; AND 5. Prescribed by or in consultation with an endocrinologist. <u>STAGE 3 TYPE 1 DIABETES</u> 1. Individual is 8 through 17 years of age (Tzield, 2026); AND 2. Documentation demonstrates recent diagnosis of Stage 3 T1D, defined as diagnosis within 8 weeks prior to treatment initiation (Tzield, 2026); AND 3. Documentation confirms autoimmune Type 1 Diabetes including at least one positive pancreatic islet autoantibody (e.g., Glutamic acid decarboxylase 65 (GAD) autoantibodies, Insulin autoantibody (IAA), Insulinoma-associated antigen 2 autoantibody (IA-2A); Zinc transporter 8 autoantibody (ZnT8A), Islet cell autoantibody (ICA)) or Peak C-peptide of greater than or equal to 0.2 pmol/mL on a mixed-meal tolerance test (if a mixed meal tolerance test is not available, an alternative method can be used).; AND 4. Prescribed by or in consultation with an endocrinologist; AND 5. The individual does not have evidence of ANY of the following: a. Lymphocyte count less than or equal to 1,000 lymphocytes/mcL; OR			

		b. Platelet count less than or equal to 150,000 platelets/mcL; OR c. Elevated ALT or AST greater than 2 times the upper limit of normal (ULN) or bilirubin greater than 1.5 times ULN; OR d. Laboratory or clinical evidence of acute infection with Epstein-Barr virus (FBV) or cytomegalovirus (CMV); OR e. Active serious infection or chronic active infection other than localized skin infections; AND 6. Clinical history of individual does not suggest type 2 diabetes or non-autoimmune dysglycemic conditions.			
Immune Globulin, Autoimmune, Rheumatic and Neurologic Indications	2024064	Policy reformatted for client defined customization in InterQual®.	No	November 11, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024064
Immune Globulin-Hematologic, Transplant, Infectious Disease and Miscellaneous Indications	2024065	Policy reformatted for client defined customization in InterQual®.	No	November 11, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024065