

PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMEUREMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Aripiprazole, Long-acting Injectables (e.g., Aristada, Aristada Initio, Abilify Asimtufii, Abilify Maintena)	2026014	New policy effective December 16, 2026	No	December 16, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2026014
Eptinezumab-jjmr (e.g., Vyepti)	2020007	Coverage criteria updated. INITIAL APPROVAL: 1. Individual is 18 years of age or older; (Vyepti, 2025); AND 2. Prescribed by or in consultation with a neurologist; AND 3. Individual has a diagnosis of: a. Chronic migraines [as a headache occurring on 15 or more days per month for more than 3 months, which, on at least 8 days per month, has features of a migraine headache (ICHD-3); OR b. Episodic migraines [at least 4 and fewer than 15 migraine days per month and fewer than 15 headache days per month on average during the previous 3-month period]; (Vyepti, 2025; Ashina, 2020); AND 4. Individual has had an inadequate treatment response with an 8-week trial of two of the following medications from different pharmacological classes: a. Beta-adrenergic blocking agents: Propranolol, Timolol, Metoprolol, Atenolol, nadolol (Silberstin, 2012); b. Antiepileptic agents: Divalproex Sodium, Topiramate, or Valproate Sodium; (Silberstin, 2012); c. Antidepressant agents: Amitriptyline or Venlafaxine; (Silberstin, 2012); d. Angiotensin receptor blocking agent: Candesartan. (Silberstin, 2012);	No	December 16, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2020007

		e. Botulinum toxin (for chronic migraine, AAN 2016); AND 5. Individual must not be taking concurrently other preventive CGRP inhibitor (e.g., Emgality, Aimovig) (AAN 2016); AND 6. If request is for dose 300 mg, individual has completed at least 3 doses of 100 mg with partial or inadequate response. AUTHORIZATION RENEWAL 1. Manageable or no side effects; AND 2. Individual will not be taking concurrently with other preventive CGRP inhibitor (e.g., Emgality, Aimovig) (AAN 2016).			
Romiplostim (e.g., Nplate)	2008025	Title updated. Initial coverage criteria updated for immune thrombocytopenia. 1. Individual has a diagnosis of immune thrombocytopenia (ITP) (Nplate, 2025) confirmed by a specialist; AND 2. Individual is 1 year of age or older (Nplate, 2025); AND 3. Individual has had an insufficient response to other treatment regimens that include corticosteroids, immunoglobulins, and/or splenectomy (Nplate, 2025); AND 4. Individual has an initial (untransfused) platelet count less than 30,000/mcL OR non-life-threatening mucosal bleeding; AND 5. If individual is 18 years of age or younger, then diagnosis of ITP has been present for at least six months (Nplate, 2025). Coverage criteria updated for chemotherapy induced thrombocytopenia. 1. Use of this medication in supportive care of oncology patient is listed in one of the following sources: a. FDA label, in accordance with the specific indication; OR	No	December 16, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2008025

		b. Accepted off-label use based on Category 1 or 2A designation found in the most recent edition of the National Comprehensive Cancer Network® (NCCN®) Drugs & Biologics Compendium (NCCN Compendium®) or NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) (add guideline and category in comment); AND 2. The individual does not have a clinically significant contraindication (such as that documented by a black box warning) compromising the safety or efficacy of the requested treatment.			
Reslizumab (e.g., Cinqair)	2018008	Policy coverage criteria updated. INITIAL APPROVAL 1. Individual is 18 years of age or older; AND 2. Individual has a diagnosis of severe eosinophilic asthma as evidenced by blood eosinophil level ≥ 400 cells/mcL in the last 4 weeks or sputum eosinophil count $\geq 3\%$ and confirmed by asthma specialist; AND 3. Positive bronchodilator responsiveness test evidenced by an increase in FEV1 greater than 12% and greater than 200 mL for adults and (less than 12% for children (less than 18 years of age); AND 4. Individual has continued symptoms or findings after ≥ 3 months of therapy and at least one of the following (ERS/ATS, 2014): a. A history of 2 or more exacerbations in the previous year, requiring bursts of systemic steroids (greater than 3 days each); OR b. At least one exacerbation requiring hospitalization, ICU stay or mechanical ventilation in the previous year; OR c. Asthma Control Questionnaire (ACQ) ≥ 1.5; OR	No	December 16, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2018008

		d. Asthma Control Test (ACT) < 20; OR e. Pre-bronchodilator forced expiratory volume in 1 second (FEV1) < 80% predicted; AND 5. Individual will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, LABA, LTRA or theophylline) in combination with mepolizumab; AND 6. Individual is not being treated concurrently with another biologic agent for the same or similar condition (such as benralizumab, dupilumab, omalizumab, mepolizumab or tezepelumab); AND 7. Individual does not have any of the following conditions: a. Aspirin-exacerbated respiratory disease (AERD) or NSIAD-exacerbated respiratory disease (NERD) – consists of 3 clinical features: asthma, nasal polyps, and sensitivity to aspirin and other NSAIDs; OR b. Atopic dermatitis; OR c. Eosinophilic esophagitis; OR d. Eosinophilic granulomatosis with polyangiitis (EGPA) (Churg-Strauss syndrome); OR e. Nasal polyposis; OR f. Hypereosinophilic syndromes (other than severe eosinophilic asthma). AUTHORIZATION RENEWAL 1. Manageable or no side effects; AND 2. Treatment with reslizumab has resulted in clinical improvement as documented by one or more of the following: a. Decreased utilization of rescue medications; OR b. Decreased frequency of exacerbations (defined as worsening of asthma that requires an increase in ICS dose or			
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		treatment with systemic corticosteroids), hospitalizations, and/or ER/urgent visits; OR c. Decreased asthma-related symptoms; OR d. Improved lung function.			
Emapalumab-lzsg (e.g., Gamifant)	2019013	Coverage criteria updated for primary hemophagocytic lymphohistiocytosis. INITIAL APPROVAL: 1. Individual has a diagnosis of Primary hemophagocytic lymphohistiocytosis (HLH) confirmed by a specialist (Gamifant, 2025): a. Refractory disease (see policy guidelines); OR b. Recurrent disease (see policy guidelines); OR c. Progressive disease; OR d. Active disease with intolerance or contraindication to conventional HLH therapy (for example, etoposide, dexamethasone, methotrexate, hydrocortisone, alemtuzumab (Gamifant, 2025; Locatelli, 2020); AND e. Documentation of primary HLH established by a hematologist, oncologist, immunologist, or transplant specialist based on clinical, laboratory, pathologic, and/or genetic findings; AND 2. One of the following: a. Hypertriglyceridemia defined as fasting triglycerides greater than or equal to 265 milligrams per deciliter of blood mg/dL (greater than 3 millimoles per liter of blood); OR b. Hypofibrinogenemia defined as fibrinogen less than or equal to 150mg/dL; OR 3. Hemophagocytosis in bone marrow, spleen, or lymph nodes with no evidence of malignancy; OR 4. Low or absent natural killer cell activity; OR	No	December 16, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2019013

		5. Ferritin greater than or equal to 500 micrograms per liter of blood (a ferritin greater than 3,000 micrograms per liter of blood is more specific for HLH; a ferritin greater than 10,000 micrograms per liter of blood is highly suggestive of HLH especially in children with no reason for iron overload); OR 6. Soluble CD25 greater than or equal to 2400 units per milliliter of blood. AUTHORIZATION RENEWAL 1. Manageable or no side effects; AND 2. Condition improved with treatment (for example, improvement in initial clinical or laboratory parameters); AND 3. Dose has been titrated to the minimum dose and frequency necessary to achieve satisfactory improvement as defined by FDA labeling for Emapalumab-lzsg (e.g., Gamifant). Coverage criteria updated for HLH/Macrophage activation syndrome. INITIAL APPROVAL: 1. Individual has a diagnosis of HLH/macrophage activation syndrome (MAS) confirmed by a specialist; AND 2. Individual has known or suspected Still's disease, [i.e., systemic Juvenile Idiopathic Arthritis (sJIA) or adult-onset Still's disease (AOSD)] (Gamifant, 2025); AND 3. Individual has one of the following: a. An inadequate response or intolerance to high-dose glucocorticoids; OR b. Intolerance or contraindication to glucocorticoids; OR c. Recurrent MAS; AND 7. Documentation of at least one of the following (Gamifant, 2025): a. Ferritin greater than 684 micrograms per liter of blood; AND			
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		b. Platelet count is less than or equal to 181,000 cells per microliter of blood; OR c. AST greater than 48 units per liter; OR d. Triglycerides greater than 156 milligrams per deciliter of blood; OR e. Fibrinogen less than or equal to 360 milligrams per deciliter of blood. AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND 2. Condition improved with treatment (for example, improvement in initial clinical or laboratory parameters); AND 3. Dose has been titrated to the minimum dose and frequency necessary to achieve satisfactory improvement as defined by FDA labeling for Emapalumab-lzsg (e.g., Gamifant).			
Enzyme Replacement Therapy (ERT) for Fabry Disease: Agalsidase Beta (e.g., Fabrazyme) and Pegunigalsidase alfa (e.g., Elfabrio)	2023013	Initial coverage criteria updated for Agalsidase Beta (e.g., Fabrazyme). 1. Individual has a diagnosis of Fabry's disease confirmed by a specialist (Fabrazyme, 2024); AND 2. Individual is age 2 years and older (Fabrazyme, 2024); AND 3. Individual is a biological male with Fabry disease confirmed by leukocyte assay or GLA gene mutation analysis; OR 4. Individual is a biological female with Fabry disease confirmed by GLA gene mutation analysis and symptoms or findings associated with active disease; AND 5. Individual will not be using concurrently with another medication treating Fabry disease (for example, migalastat or pegunigalsidase alfa).	No	December 16, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023013
Tildrakizumab-asmn (e.g., Ilumya)	2022048	Authorization renewal coverage criteria updated.	No	December 16, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022018

		1. Condition improved with treatment as documented by positive clinical response; AND 2. Manageable or no side effects; AND 3. Individual is not using the medication in combination with any other biologic intended for treatment of plaque psoriasis, including but not limited to: TNF inhibitor, PDE4 inhibitor, any IL inhibitor, or tyrosine kinase inhibitor.			
Chemodenervation, Botulinum Toxins	2018002	Initial coverage criteria updated. 1. Disorders associated with spasticity or dystonia: a. Blepharospasm associated with dystonia in individuals 12 years of age and older (Jankovic, 2009; Nussgens, 1997; Roggenkamper, 2006); OR b. Facial nerve (VII) disorders confirmed by specialist (Soares, 2014) (for example, hemifacial spasm (Dashtipour, 2015); OR c. Hereditary spastic paraparesis (Shribman, 2019); OR d. Idiopathic torsion dystonia (Duarte, 2016); OR e. Laryngeal spasm (Simpson, 2008); OR f. Multiple sclerosis or Schilder's disease (deSeze, 2002); OR g. Neuromyelitis optica (Esquenazi, 2013); OR h. Organic writer's cramp (FDA, 2021); OR i. Orofacial dyskinesia, Meige syndrome (Soares, 2014); OR j. Spastic hemiplegia (Shribman, 2019); OR k. Symptomatic torsion dystonia (Duarte, 2016); OR l. Treatment of upper limb spasticity confirmed by specialist in individuals 2 years of age and older when occupational therapy is	No	December 16, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2018002

		planned or continued (FDA, 2021); OR m. Treatment of lower limb spasticity confirmed by specialist in individuals 2 years of age and older when occupational therapy is planned or continued (FDA, 2021); OR 2. Disorders of the bladder: a. Treatment of overactive bladder (OAB) confirmed by specialist with symptoms of urge urinary incontinence, urgency, and frequency, in individuals 5 years of age and older who have continued symptoms after behavioral therapy for at least 8 weeks and an inadequate response to or are intolerant of an anticholinergic medication or beta-3 agonist. (FDA, 2021); OR b. Treatment of urinary incontinence due to detrusor overactivity confirmed by specialist associated with neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication or beta-3 agonist. (FDA, 2021); OR c. Treatment of neurogenic detrusor overactivity (NDO) confirmed by specialist in pediatric individuals 5 years of age and older who have continued symptoms after behavioral therapy for at least 8 weeks and an inadequate response to or are intolerant of anticholinergic medication. (FDA, 2021); OR 3. Prophylaxis of chronic migraine headaches in the following situations: a. Initial approval for 12 months in adult individuals who: i. Have chronic migraine confirmed by neurologist			
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		or headache specialist; AND ii. Have symptoms that persist despite adequate trials of at least 2 agents from different classes of medications in the treatment of chronic migraine headaches (e.g., antidepressants, antihypertensives, CGRP inhibitors and antiepileptics) (Garza, 2021); AND iii. Individual will be using botulinum toxin for migraine prevention only; OR b. Continuing treatment beyond 12 months: i. Manageable or no side effects; OR ii. Condition improved with treatment; AND iii. Planned administration at least 12 weeks since prior botulinum toxin administration 4. Treatment of cervical dystonia (spasmodic torticollis) confirmed by specialist in individuals 16 years of age and older, to reduce the severity of abnormal head position and neck pain. (FDA, 2021); OR 5. Treatment of strabismus confirmed by ophthalmologist in individuals 12 years of age and older. (FDA, 2021); OR 6. Esophageal Achalasia confirmed by gastroenterologist unresponsive to dilation therapy or who are poor surgical candidates (Friedmacher, 2012); OR 7. Chronic anal fissure confirmed by specialist (Brisinda, 1999); OR 8. Chronic sialorrhea confirmed by specialist; OR 9. Hirschsprung disease confirmed by specialist with the development of			
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		obstructive symptoms after pull-through operation. (Langer, 2017); OR 10. Primary axillary/ palmar or plantar/ craniofacial hyperhidrosis confirmed by dermatologist when all the following are met: a. Individual is 18 years of age or older; AND b. Individual has failed a trial of at least one week or intolerant of at least one prescription strength antiperspirants; OR 11. Focal limb dystonia confirmed by specialist; OR 12. Frey's syndrome confirmed by specialist; OR 13. Coverage is not provided for the following conditions: a. Neurologic indications such as: i. Headaches, except as noted above for prevention of chronic migraine headache including maintenance therapy; OR ii. Essential tremor; OR iii. Tinnitus; OR iv. Chronic motor tic disorder and tic associated with Tourette syndrome (motor tics); OR b. Urological indications such as: i. Benign prostatic hyperplasia; OR ii. Interstitial cystitis; OR iii. Detrusor sphincteric dyssynergia (after spinal cord injury); OR c. Pain due to multiple etiologies such as: i. Chronic low back pain; OR ii. Joint pain; OR iii. Mechanical neck disorders; OR			
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		iv. Neuropathic pain after neck dissection; OR v. Myofascial pain syndrome; OR vi. Temporomandibular joint disorders; OR vii. Trigeminal neuralgia; OR viii. Pain after hemorrhoidectomy or lumpectomy; OR ix. Lateral epicondylitis; OR x. Prevention of pain associated with breast reconstruction after mastectomy; OR xi. Chronic pelvic/perineal pain; OR d. Gastrointestinal motility disorders such as: i. Internal anal sphincter achalasia; OR ii. Anismus (pelvic floor dyssynergia); OR iii. Gastroparesis; OR e. Any cosmetic purpose/indication; OR f. Other miscellaneous conditions such as: i. Facial wound healing; OR ii. Depression.			
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