PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	**POLICY NUMBER**	**CRITERIA CHANGE**	**MATERIAL AMENDEMENT**	**EFFECTIVE DATE**	**LINK TO FULL POLICY**
Tagraxofusp-erzs (e.g., Elzonris)	2020012	Continuation criteria updated to authorization renewal criteria. 1. Condition improved with treatment such as stabilization of disease, decrease in size of tumor(s) or tumor spread; AND 2. Manageable or no side effects; AND 3. Documentation of the following, (i.e., albumin, liver functions, weights, LFT's etc.).	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2020012
Ustekinumab (e.g., Stelara)	2021028	Preferred/non-preferred product list updated. Initial criteria for Crohn's disease updated expanding the age from 18 years of age and older to 2 years of age and older. Authorization renewal criteria updated for all indications. Preferred Products: HCPCS, Brand, Name Generic Name Q9996, Pyzchiva SC, Ustekinumab-ttwe Q9997, Pyzchiva IV, Ustekinumab-ttwe Q9998, Selarsdi IV, Ustekinumab-aekn Q9998, Selarsdi SC, Ustekinumab-aekn Q5100, Yesintek SC, Ustekinumab-kfce Q5100, Yesintek IV, Ustekinumab- kfce Non-Preferred Products: HCPCS, Brand Name, Generic Name Q5098, Imuldosa SC, Ustekinumab-srlf Q5098, Imuldosa IV, Ustekinumab-srlf Q9999, Otulfi SC, Ustekinumab-aauz Q9999, Otulfi IV, Ustekinumab-aauz J3357, Stelara SC, Ustekinumab J3358, Stelara IV, Ustekinumab Q5099, Steqeyma SC, Ustekinumab-stba Q5099, Steqeyma IV, Ustekinumab-stba Q5164, Starjemza SC, Ustekinumab-hmny Q5164, Starjemza IV, Ustekinumab-hmny Q5137, Wezlana SC, Ustekinumab-auub Q5138, Wezlana IV, Ustekinumab-auub	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021028

		<u>CROHN'S DISEASE</u> INITIAL APPROVAL: 1. Individual is greater than or equal to 2 years of age (Stelara, 2026); AND 2. Individual has a diagnosis of moderate to severe Crohn's disease supported by the submitted medical records; AND 3. Individual has an active disease with documented inadequate response (trial of greater than or equal to 3 months) to at least one conventional therapy option (e.g., betamethasone, methylprednisolone, prednisolone, prednisone, budesonide, hydrocortisone, azathioprine, mercaptopurine, sulfasalazine, mesalamine, methotrexate) (Lichtenstein, 2018); OR 4. Individual has an active disease with intolerance or contraindication to at least one conventional therapy option (e.g., betamethasone, methylprednisolone, prednisolone, prednisone, budesonide, hydrocortisone, azathioprine, mercaptopurine, sulfasalazine, mesalamine, methotrexate) (Van Rheenen, 2021); OR 5. Individual has previously received a biologic (e.g., adalimumab, infliximab, certolizumab pegol, risankizumab, ustekinumab, natalizumab, vedolizumab) or Janus Kinase Inhibitor (e.g., upadacitinib) indicated for moderate to severe Crohn's disease; OR 6. Individual has fistulizing disease (Feuerstein, 2021); AND 7. Individual is not using the medication in combination with any other biologic, including but not limited to: TNF inhibitor, IL-36 inhibitor, integrin inhibitor, any other IL inhibitor, or Janus kinase inhibitor. AUTHORIZATION RENEWAL: 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, including but not limited to: TNF inhibitor, IL-36 inhibitor, PDE4 inhibitor, any other IL inhibitor, or Janus kinase inhibitor.			
Denosumab (e.g., Xgeva and Prolia)	2017009	Off-label indications updated for Denosumab (e.g., Xgeva and Prolia). Authorization renewal criteria updated. FDA Labeled Indications: The use of this drug is covered if an FDA-approved oncologic indication exists [not listed as an indication below with the member meeting all of the additional requirements of the prescribing information (package insert listed in the "Indications and Usage"). DENOSUMAB (E.G., PROLIA) AND BIOSIMILARS, DENOSUMAB-BMWO (E.G., STOBOCLO), DENOSUMAB-DSSB (E.G., OSPOMYV), DENOSUMAB-BNHT (E.G., CONEXXENCE), DENOSUMAB-BBDZ (E.G., JUBBONTI), DENOSUMAB-KYQQ (E.G., BOSAYA) (effective 4/1/2026), and DENOSUMAB-NXXP (E.G., BILDYOS) (effective 4/1/2026) INITIAL APPROVAL: 1. Prevention of fractures in men and postmenopausal women who are intolerant to or have a medical contraindication to other available osteoporosis therapies (e.g., bisphosphonates) when one of the following criteria are met (Prolia, 2025): a. Individual has osteoporosis [defined as a bone mineral density (BMD) T-score in the spine, femoral neck, total hip or distal 1/3 of the radius of less than or equal to -2.5 as compared to a young-adult reference population OR a clinical diagnosis based on history of low trauma fracture (fragility fracture); OR	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017009

		b. Individual has osteopenia (a pre-treatment T-score between -1 and -2.5) and one of the following: i. FRAX 10-year fracture probability greater than or equal to 20%; OR ii. FRAX hip fracture probability greater than or equal to 3%; OR c. Individual has had at least one osteoporotic fracture (minimal trauma fragility fracture); OR d. Individual has two or more risk factors for osteoporotic fracture. 2. Prevention of osteoporosis in individuals receiving aromatase inhibitors (i.e., anastrozole, letrozole, exemestane) for breast cancer (Prolia, 2025), including prevention of osteoporosis in postmenopausal (natural or induced) individuals with invasive, inflammatory and ductal carcinoma in situ (DCIS), encapsulated or solid papillary carcinoma (SPC) breast cancer receiving adjuvant aromatase inhibition therapy along with calcium and vitamin D supplements to maintain or improve bone mineral density and reduce risk of fractures (NCCN 2A); OR 3. Treatment of glucocorticoid-induced osteoporosis [defined as a bone mineral density (BMD) T-score in the spine , femoral neck, total hip or distal 1/3 of the radius of less than or equal to -2.5 as compared to a young-adult reference population OR a clinical diagnosis based on history of a low trauma fracture (fragility fracture)] in men and women at high risk*[see policy guidelines] of fracture who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and expected to remain on glucocorticoids for at least 6 months (Prolia, 2025); OR 4. Treatment to increase bone mass in men at high risk for fracture receiving androgen			

		deprivation therapy for nonmetastatic prostate cancer (Prolia, 2025). AUTHORIZATION RENEWAL: 1. Condition stable or improved with treatment as evidenced by a clinically significant response to therapy (including but not limited to confirmation of no new fractures or reduction of fractures, or no worsening vertebral fractures, or no clinically significant adverse reaction); AND 2. Manageable or no side effects; AND 3. When on therapy more than or equal to 24 months, a repeat BMD demonstrates a stable or increase in BMD. Off-label Indications: The use of this drug for off-label indications not listed below is subject to policy 2000030. INITIAL APPROVAL: The following indications are covered when the individual meets the related NCCN category 1 or 2A recommendations specific to the indications below (e.g., histology, cancer staging, surgical status, mono- or combination therapy, and previous lines of therapy): 1. Prostate Cancer (NCCN 2A): a. For treatment-related bone loss in those receiving androgen deprivation therapy (ADT) when the absolute fracture risk warrants drug therapy; OR 2. Systemic Mastocytosis (NCCN 2A): a. Second-line therapy for osteopenia/osteoporosis in individuals with bone pain not responding to bisphosphonates or for individuals who are not candidates for bisphosphonates because of renal insufficiency; OR			

		3. Ductal Carcinoma in situ (DCIS), Invasive, and Inflammatory Breast Cancer (NCCN 2A): a. Consider in postmenopausal (natural or induced) individuals receiving adjuvant aromatase inhibition therapy along with calcium and vitamin D supplementation to maintain or improve bone mineral density and reduce risk of fractures. AUTHORIZATION RENEWAL: 1. Condition stable or improved with treatment as evidenced by a clinically significant response to therapy (including but not limited to confirmation of no new fractures or reduction of fractures, or no worsening vertebral fractures, or no clinically significant adverse reaction); AND 2. Manageable or no side effects; AND 3. When on therapy more than or equal to 24 months, a repeat BMD demonstrates a stable or increase in BMD. DENOSUMAB (E.G., XGEVA) AND BIOSIMILARS DENOSUMAB-BMWO (E.G., OSENVELT), DENOSUMAB-DSSB (E.G., XBRYK), DENOSUMAB-BBDZ (E.G., WYOST), DENOSUMAB-BNHT (E.G., BOMYNTRA), DENOSUMAB-KYQQ (E.G., AUKELSO) (effective 4/1/2026), and DENOSUMAB-NXXP (E.G., BILPREVDA) (effective 4/1/2026) INITIAL APPROVAL: 1. Supportive therapy and prevention of skeletal-related events (SREs)* [see policy guidelines] in individuals with Bone Metastases from Solid Tumors (Xgeva, 2020; NCCN 2A) (excluding prostate cancer unless castration resistant/recurrent) including but not limited to: a. Breast Cancer; OR b. Renal Cell Carcinoma; OR			

		c. Non-Small Cell Lung Cancer (NSCLC); OR d. Castration-resistant Prostate Cancer, [osteoclast inhibition (with bisphosphonates or denosumab) does not significantly decrease the rate of skeletal-related events in men with hormone-sensitive metastatic disease]; OR e. Thyroid Cancer (Follicular, Hürthle Cell, Medullary, or Papillary Carcinomas). 2. Supportive therapy and prevention of skeletal-related events (SREs)* [see policy guidelines] in individuals with multiple myeloma (Xgeva, 2020; NCCN 2A); OR 3. Treatment of adults and skeletally mature adolescents with Giant Cell Tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity, and/or unresectable axial lesions for individuals: (Xgeva, 2020; NCCN 2A): a. As a single agent or in combination with interferon alfa or radiation therapy for localized disease; OR b. As a single agent for metastatic disease; OR c. As a single agent prior to surgery for resectable local recurrence (NCCN 2A); OR d. As a single agent for unresectable metastatic recurrence (NCCN 2A); OR 4. Treatment of Hypercalcemia of Malignancy refractory to bisphosphonate therapy (Xgeva, 2020). AUTHORIZATION RENEWAL: 1. Condition stable or improved with treatment as evidenced by a clinically significant response to therapy (including but not limited to confirmation of no new fractures or reduction of fractures, or no worsening vertebral fractures, or no clinically significant adverse reaction); AND			

		2. Manageable or no side effects; AND 3. When on therapy more than or equal to 24 months, a repeat BMD demonstrates a stable or increase in BMD. Off-label Indications: The use of this drug for off-label indications not listed below is subject to policy 2000030. INITIAL APPROVAL: The following indications are covered when the individual meets the related NCCN category 1 or 2A recommendations specific to the indications below (e.g., histology, cancer staging, surgical status, mono- or combination therapy, and previous lines of therapy): 1. Bone Cancer: a. Giant Cell Tumor of Bone (NCCN 2A); OR 2. Multiple Myeloma (NCCN 2A); OR 3. Prostate Cancer (NCCN 1); OR 4. Non-Small Cell Lung Cancer (NCCN 2A); OR 5. Kidney Cancer (NCCN 2A); OR 6. Thyroid carcinoma when bone metastasis exists (NCCN 2A): a. Papillary Carcinoma; OR b. Follicular Carcinoma; OR c. Oncocytic Carcinoma; OR d. Medullary Carcinoma; OR e. Anaplastic Carcinoma - (Consider use for palliative care for bone metastases); OR 7. Invasive and Inflammatory Breast Cancer: f. Used with calcium and Vit D supplementation in addition to systemic therapy or endocrine therapy for bone metastasis in individuals with expected survival of greater than or equal to 3 months and adequate renal function (NCCN 1).			

		AUTHORIZATION RENEWAL: 1. Condition stable or improved with treatment as evidenced by a clinically significant response to therapy (including but not limited to confirmation of no new fractures or reduction of fractures, or no worsening vertebral fractures, or no clinically significant adverse reaction); AND 2. Manageable or no side effects; AND 3. When on therapy more than or equal to 24 months, a repeat BMD demonstrates a stable or increase in BMD. Please see the NCCN Drugs and Biologics Compendium for a complete list of NCCN 1 & 2A indications. To view the most recent and complete version of the guideline or Compendium, go online to NCCN.org. Please note, NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.			
Tebentafusp-tebn (e.g., Kimmtrak)	2022023	Authorization renewal criteria updated. AUTHORIZATION RENEWAL: 1. Condition improved with treatment as evidenced by a positive clinical response defined by stabilization of disease or decrease in size of tumor or tumor spread; AND 2. Manageable or no side effects.			https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022023
Tisotumab vedotin-tftv (e.g., Tivdak)	2022025	Authorization renewal criteria updated for FDA labeled and off-label indications. AUTHORIZATION RENEWAL: 1. Condition improved with treatment as evidenced by a positive clinical response defined by stabilization of disease or decrease in size of tumor or tumor spread; AND 2. Manageable or no side effects.			https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022025

Sirolimus protein-bound particles for injectable suspension (e.g., Fyarro)	2022022	Authorization renewal criteria updated. AUTHORIZATION RENEWAL: 1. Condition stable or improved with treatment as evidenced by disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread; AND 2. Manageable or no side effects.			https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022022
Pemetrexed (e.g., Alimta)	2017020	Authorization renewal criteria updated. AUTHORIZATION RENEWAL: 3. Condition improved with treatment as defined by stabilization of disease or decrease in size of tumor or tumor; AND 4. Manageable or no side effects.	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=20170202
Mosunetuzumab-axgb (e.g. Lunsumio)	2023024	Policy updated with new subcutaneous formulation product (Lunsumio Velo). Updated off-label indications. 1. B-Cell Lymphomas: a. Classic Follicular Lymphoma (NCCN 2A); OR b. Mantle Cell Lymphoma (NCCN 2A); OR c. Diffuse Large B-Cell Lymphoma (NCCN 2A); OR d. High-Grade B-Cell Lymphomas (NCCN 2A); OR e. HIV-Related B-Cell Lymphomas (NCCN 2A); OR f. Post-Transplant Lymphoproliferative Disorders (NCCN 2A).	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023024
Belimumab (e.g., Benlysta)	2021033	After full review and evaluation, the InterQual® Criteria has been adopted in part as Coverage Policy. Because belimumab has not been studied in concurrent use with other biologics, the Plan elected to keep the continuation criteria point regarding use with other biologics.	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021033

		Policy to transition to InterQual® effective August 19, 2026			
Toripalimab (e.g., Loqtorzi)	2024015	Authorization renewal criteria updated for FDA labeled and off-label indications. Off-label indications updated. AUTHORIZATION RENEWAL for up to 12 months: for 12 months: 1. Manageable or no side effects; AND 2. Condition stable or improved with treatment. <u>Off Label Indications:</u> 1. COLON CANCER (NCCN 2A); OR 2. APPENDICEAL CANCER (NCCN 2A); OR 3. HEAD AND NECK CANCERS (NCCN 2A); OR a. Cancers of the Nasopharynx (NCCN 1 and 2A); OR b. Very Advanced Head and Neck Cancer (NCCN 1 and 2A); OR 4. SMALL BOWEL ADENOCARCINOMA (NCCN 2A); OR 5. ANAL CARCINOMA (NCCN 2A); OR 6. RECTAL CANCER (NCCN 2A).	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024015
Anifrolumab-fnia (e.g., Saphnelo)	2022012	Initial approval and authorization renewal criteria updated. INITIAL APPROVAL: 1. Individual is aged 18 years or older (Saphnelo, 2026); AND 2. Individual has a diagnosis of active moderate-severe systemic lupus erythematosus (SLE) diagnosed by specialist; AND 3. Individual does not have a severe active central nervous system lupus or severe active class III, IV or V lupus nephritis diagnosed by nephrologist or rheumatologist (Saphnelo, 2026); AND 4. Medical records (such as chart notes, lab reports) are provided documenting the	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022012

		presence of autoantibodies relevant to SLE (for example, ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins); AND 5. Individual is currently continuing antimalarial therapy (e.g., hydroxychloroquine) or antimalarial therapy is contraindicated; AND 6. Disease remains active while on corticosteroids, NSAIDs, or immunosuppressants and individual will be using anifrolumab in combination with standard therapy (for example, corticosteroids, antimalarials, and/or immunosuppressants [but not other biologics]); 7. Individual is not using the medication in combination with other biologic medication, for example: B Lymphocyte Stimulator Inhibitors (such as belimumab), TNF inhibitors (such as adalimumab, certolizumab, etanercept, golimumab), IL inhibitors (such as reslizumab, depemokimab, benralizumab, mepolizumab) B cell inhibitors (such as rituximab or ocrelizumab), and Selective Co-stimulation modulators (such as abatacept). AUTHORIZATION RENEWAL: 1. Condition stable or improved with treatment; AND 2. Manageable or no side effects 3. Individual is using in combination with standard therapy (for example, corticosteroids, antimalarials, and/or immunosuppressants; AND 4. Individual is not using the medication in combination with other biologic for example: TNF inhibitors, IL inhibitors, B cell inhibitors, and Selective Co-stimulation modulators.			
Talimogene laherepvec (e.g., Imlygic)	2025015	Authorization renewal criteria added for FDA labeled and off-label indications. AUTHORIZATION RENEWAL:	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025015

		1. Condition stable or improved with treatment; OR 2. Manageable or no side effects; AND 3. Injectable lesions continue to be present.			
Contraceptive Implants (e.g.,Nexplanon)	2025016	Criteria updated with dosing change from 3 years to 5 years. 1. Female individual will be using contraceptive implants (e.g., Nexplanon) as a prevention of pregnancy (Nexplanon, 2025).	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025016
Cosibelimab-ipdl (e.g., Unloxcyt)	2025017	Authorization renewal criteria updated. AUTHORIZATION RENEWAL: 1. Condition stable or improved with treatment as evidenced by objective benefit from continued treatment as defined by stabilization of disease or decrease in size of tumor and spread; AND 2. Manageable or no side effects.	No	August 19, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025017