

**PROVIDER NOTIFICATION OF POLICY CRITERIA  
CHANGE**

POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMENDMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Inclisiran (e.g., Leqvio)	2022016	<p>Initial approval coverage criteria updated for clinical atherosclerotic cardiovascular disease.</p> <ol style="list-style-type: none"> <li>1. Individual is 18 years of age or older (Inclisiran, 2026); <b>AND</b></li> <li>2. Individual is intolerant or has failed a 90-day trial of PCSK9 inhibitor (e.g., alirocumab, evolocumab) (Greco, 2025); <b>AND</b></li> <li>3. Individual has a history of ASCVD or one of the following (Inclisiran, 2026; AHA/ACC, 2018):               <ol style="list-style-type: none"> <li>a. Acute coronary syndrome; <b>OR</b></li> <li>b. Myocardial infarction; <b>OR</b></li> <li>c. Stable or unstable angina; <b>OR</b></li> <li>d. Coronary or other arterial revascularization procedure (e.g., PTCA, CABG); <b>OR</b></li> <li>e. Stroke of presumed atherosclerotic origin; <b>OR</b></li> <li>f. Transient ischemic attack (TIA); <b>OR</b></li> <li>g. Peripheral arterial disease of presumed atherosclerotic origin; <b>OR</b></li> <li>h. Finding from CT angiogram or catheterization consistent with ASCVD; <b>OR</b></li> <li>i. A coronary calcium score of 300 or greater (Budoff, 2023); <b>AND</b></li> </ol> </li> <li>4. Individual meets at least <b>ONE</b> of the following requirements (AHA/ACC, 2018):               <ol style="list-style-type: none"> <li>a. Individual has a current LDL-C level greater than or equal to 70 after at least three months of an adherent treatment with a high-intensity statin (atorvastatin greater than or equal to 40 mg or rosuvastatin greater than or</li> </ol> </li> </ol>	Yes	July 29, 2026	<a href="https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022016">https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022016</a>

		<p>equal to 20 mg daily) plus ezetimibe 10 mg daily; <b>OR</b></p> <p>b. Individual has a current LDL-C level greater than or equal to 70 with contraindication*or failure of statin and is taking ezetimibe with or without other lipid lowering medications at maximally tolerated doses or at the maximum doses approved by the FDA; <b>OR</b></p> <p>c. Individual has a current LDL-C level greater than or equal to 70 on high intensity statin but has intolerance or failure of ezetimibe.</p> <p>Initial approval coverage criteria updated for heterozygous familial and homozygous familial hypercholesterolemia.</p> <p>1. Individual is 12 years of age or older (Inclisiran, 2026); <b>AND</b></p> <p>2. Individual has a definite diagnosis of familial hypercholesterolemia as evidenced by meeting one of the following diagnostic criteria (Inclisiran, 2026):</p> <p>a. Simon-Broome Diagnostic Criteria for definite FH</p> <p>i. Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthomas in first- (parent, sibling, or child) or second-degree relative (grandparent, uncle, or aunt); <b>OR</b></p> <p>b. Dutch Lipid Clinic Network Criteria for definite FH</p> <p>i. Total score greater than 8 points; <b>AND</b></p> <p>3. Individual meets at least <b>ONE</b> of the following requirements (AHA/ACC, 2018):</p> <p>a. With ASCVD: Criteria in Section A must be met; <b>OR</b></p>			
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		<p>b. Without ASCVD: Individual has a current LDL-C level greater than or equal to 100 after at least three months of an adherent treatment with a high-intensity statin (atorvastatin greater than or equal to 40 mg or rosuvastatin greater than or equal to 20 mg daily) plus ezetimibe 10 mg daily; <b>OR</b></p> <p>4. Individual has a current LDL-C level greater than or equal to 100 with contraindication* to statin and is taking ezetimibe with or without other lipid lowering medications at maximally tolerated doses or at the maximum doses approved by the FDA (AHA/ACC, 2018); <b>OR</b></p> <p>5. Individual has a current LDL-C level greater than or equal to 100 and contraindication* to both statin and ezetimibe (AHA/ACC, 2018).</p> <p>Authorization renewal criteria updated for clinical atherosclerotic cardiovascular disease and heterozygous familial and homozygous familial hypercholesterolemia.</p> <ol style="list-style-type: none"> <li>1. Condition improved with treatment from baseline. Pretreatment and current LDL-C levels, including percentage and absolute reductions in LDL-C. If triglycerides are greater than or equal to 400, a direct LDL measurement is required; <b>AND</b></li> <li>2. Manageable or no side effects.</li> </ol>			
Ambulatory Blood Pressure Monitoring	1997005	<p>Criteria revised.</p> <p>Ambulatory blood pressure monitoring (ABPM) over a 24-hour period meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered for individuals with elevated office BP when performed 1 time to differentiate between "white coat hypertension" and</p>	Yes	August 1, 2026	<a href="https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1997005">https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1997005</a>

		<p>true hypertension, and when the following conditions are met (see Policy Guidelines section for considerations in pediatric patients):</p> <ul style="list-style-type: none"><li>• Office BP elevation is in the mild-to-moderate range (&lt;180/110 mm Hg), not requiring immediate treatment with medications; and</li><li>• There is an absence of hypertensive end-organ damage on physical examination and laboratory testing.</li></ul> <p><b><u>POLICY GUIDELINES</u></b></p> <p>For pediatric individuals, the principles of ABPM use to confirm a diagnosis of hypertension are the same as in adults, but there are special considerations as follows (Flynn, 2022):</p> <ul style="list-style-type: none"><li>• A device should be selected that is appropriate for use in pediatric individuals, including use of a cuff size-appropriate to the child's size.</li><li>• Threshold levels for the diagnosis of hypertension should be based on pediatric normative data, which use gender and height specific values derived from large pediatric populations.</li></ul>			
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