PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMENDEMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Sodium Iodide I 131 Oncologic Therapy	2021035	Authorization renewal criteria updated. AUTHORIZATION RENEWAL 1. Condition stable or improved with prior response to radioactive iodine treatment; OR 2. Repeat treatment is given at least 6 months following prior treatment (Hicon, 2021); AND 3. Manageable or no side effects.	No	09/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021035
Panitumumab (e.g., Vectibix)	2017024	FDA label and off-label authorization renewal criteria updated.Continuation criteria updated to authorization renewal criteria. Off-label indications updated. AUTHORIZATION RENEWAL 1. Condition stable or improved with no disease progression during treatment with Panitumumab (e.g., Vecitbix); AND 2. Panitumumab is NOT used in combination with medications concerning for therapeutic duplication, such as cetuximab (e.g., Erbitux), necitumumab (e.g., Portrazza), erlotinib (e.g., Tarceva) or gefitinib (e.g., Iressa); AND 3. Manageable or no side effects. Off-label indications updated. 1. Rectal Cancer (NCCN 2A); OR 2. Colon Cancer (NCCN 2A); OR 3. Appendiceal Adenocarcinoma (NCCN 2A); OR 4. Small Bowel Adenocarcinoma (NCCN 2A).	No	09/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017024
Retifanlimab-dlwr (e.g., Zynyz)	2023033	FDA label and off-label authorization renewal criteria updated.	No	09/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023033

		AUTHORIZATION RENEWAL 1. Condition stable or improved with treatment with disease stabilization or decrease in size of tumor or tumor spread; AND 2. Manageable or no side effects; AND 3. Has not exceeded 24 months of treatment with Retifanlimab-dlwr (e.g., Zynyz).			
Epcoritamab-bysp (e.g., Epkinly)	2023034	Initial approval and authorization renewal criteria updated for FDA label and off-label indications. <u>FDA Labeled Indications:</u> 1. Individual is 18 years of age or older; AND 2. Individual has diagnosis of CD20+ relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from indolent lymphoma and high-grade B-cell lymphoma (HGBL) (Epkinly, 2026); OR 3. Individual has diagnosis of relapsed or refractory follicular lymphoma (Epkinly, 2026; NCCN 2A) with the following characteristics: a. Individual has received two or more prior lines of systemic therapy AND epcoritamab-bysp will be used as a single agent (Epkinly, 2026); OR b. Individual will be using in combination with lenalidomide and rituximab (Epkinly, 2026); AND 4. Individual does not have any of the following: a. Central nervous system involvement or lymphoma; OR b. Allogeneic hematopoietic stem cell transplantation (HSCT) or solid organ transplant; OR c. Ongoing active infection; OR d. Known impaired T-cell immunity. AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND	No	09/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023034

		2. Condition stable or improved with treatment; AND 3. Individual will be using Epcoritamab-bysp as a single agent OR in combination with rituximab and lenalidomide. <u>Off-label Indications:</u> 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. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma a. Histologic Transformation (Richter)- NCCN 2A; OR 2. B-Cell Lymphomas: a. Classic Follicular Lymphoma- NCCN 1 and 2A; OR b. Diffuse Large B-Cell Lymphoma- NCCN 2A; OR c. Histologic Transformation of Indolent Lymphomas to 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. AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND 2. Condition stable or improved with treatment; AND 3. Individual will be using Epcoritamab-bysp as a single agent OR in combination with rituximab and lenalidomide.			

Lutetium Lu 177 Dotatate (e.g., Lutathera)	2018014	Off-label indications updated. 1. Neuroendocrine and Adrenal Tumors: a. Neuroendocrine Tumors of the Gastrointestinal Tract (Well-Differentiated Grade 1/2), Lung, and Thymus (NCCN 1 for progressive mid-gut tumors, NCCN 2A for all others); OR b. Neuroendocrine Tumors of the Pancreas (Well-Differentiated Grade 1/2) (NCCN 2A) ; OR c. Pheochromocytoma/Paraganglioma ; OR 2. Thyroid Carcinoma: a. Medullary Carcinoma (NCCN 2A).	No	09/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2018014
Bortezomib (e.g., Velcade)	2022029	Authorization renewal criteria updated for FDA labeled and off-label indications. AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND 2. Condition stable or improved with treatment. Off-label indications updated. 1. Pediatric Acute Lymphoblastic Leukemia: a. Pediatric Acute Lymphoblastic Leukemia- NCCN 2A; OR 2. Kaposi Sarcoma: a. Kaposi Sarcoma- NCCN 2A; OR b. KSHV-Associated Inflammatory Cytokine Syndrome- NCCN 2A; OR 3. Multiple Myeloma- NCCN 1 and 2A; OR 4. Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma- NCCN 2A; OR 5. Systemic Light Chain Amyloidosis- NCCN 1 and 2A; OR 6. Castleman Disease - NCCN 2A; OR 7. Pediatric Hodgkin Lymphoma: a. Classic Hodgkin Lymphoma; OR 8. B-Cell Lymphomas:	No	09/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022029

		a. Mantle Cell Lymphoma- NCCN 2A; OR 9. Acute Lymphoblastic Leukemia NCCN 2A.			
Sebelipase alfa (e.g., Kanuma)	2023035	Authorization renewal criteria updated. 1. Condition stable or improved with treatment (e.g., improvement in symptoms, improvement of lab values (LFTs, cholesterol, triglycerides), etc.); AND 2. Manageable or no side effects	No	09/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023035
Bevacizumab (e.g., Avastin) and Biosimilars for Ophthalmic Use	2024021	Authorization renewal criteria updated. 1. Condition improved with treatment; AND 2. Manageable or no side effects; AND 3. Individual is NOT using bevacizumab for sickle cell retinopathy.	No	09/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024021
Chemotherapy for Malignancy	2000030	This policy will be archived effective October 24, 2026. (See below policy, Chemotherapy and Drug Treatment Regimens for Malignancy 2026011 for coverage on or after October 24, 2026)	Yes	10/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2000030
Chemotherapy and Drug Treatment Regimens for Malignancy-Administrative Policy	2026011	New policy developed with effective date of October 24, 2026. (See above policy, Chemotherapy for Malignancy 2000030 coverage prior to October 24, 2026)	Yes	10/24/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2026011