

PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMEUREMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Respiratory Syncytial Virus, Immune Prophylaxis with Palivizumab (e.g., Synagis)	1998155	This policy will be archived effective January 1, 2027,	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1998155
Caplacizumab-yhdp (e.g., Cablivi)	2019006	Coverage criteria updated to reflect change in age to 12 years and older. First dose of Caplacizumab will usually be given in an inpatient setting. 1. Caplacizumab-yhdp (e.g., Cablivi) will be prescribed by, or in consultation of a hematologist; AND 2. Individual is at least 12 years of age or older (Sully, 2019); AND 3. Individual has a diagnosis or suspected diagnosis of acquired thrombotic thrombocytopenia purpura (aTTP) as evidenced by the following: a. Individual has presented with severe thrombocytopenia (Sully, 2019); AND b. Has presented with microangiopathic hemolytic anemia (MAHA), confirmed by red blood cell fragmentation (e.g. schistocytes) on peripheral blood smear (Sully, 2019); AND c. Testing for ADAMTS13 activity levels has been completed or is in progress (Sully, 2019); AND d. The individual will be receiving Caplacizumab in combination with plasma exchange and immunosuppressive therapy (e.g. corticosteroids, rituximab, etc.) (Cablivi, 2024) For subcutaneous doses after completion of plasma exchange:	No	December 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2019006

		1. Caplacizumab-yhdp (e.g., Cablivi) will be prescribed by, or in consultation of a hematologist; AND 2. Individual is at least 12 years of age or older; AND 3. The following has been documented for this aTTP occurrence: a. Caplacizumab treatment has been initiated for a confirmed diagnosis of aTTP; AND b. Date of last plasma exchange treatment is provided (Cablivi, 2024); AND c. Number of Caplacizumab doses remaining to complete the initial treatment course (up to 30 days post plasma exchange) (Cablivi, 2024) AND d. Individual has not had more than 2 recurrences/exacerbations of TTP while on Caplacizumab therapy (recurrence/exacerbation is defined as thrombocytopenia after initial recovery of platelet count that requires reinitiation of daily plasma exchange) (Cablivi, 2024)			
Nipocalimab (e.g., Imaavy)	2025029	Coverage criteria updated to include new FDA indication for warm autoimmune hemolytic anemia (wAIHA) added. <u>WARM AUTOIMMUNE HEMOLYTIC ANEMIA (wAIHA)</u> INITIAL APPROVAL 1. Individual is 12 years of age or older (Imaavy, 2026); AND 2. Individual has a diagnosis of warm autoimmune hemolytic anemia (wAIHA) as evidenced by ALL of the following: a. Positive direct antiglobulin test (DAT/Coombs test) consistent with IgG-mediated hemolysis; AND a. b.Evidence of active hemolysis (e.g., elevated LDH, elevated indirect bilirubin, reduced haptoglobin, or increased reticulocyte count); AND	No	December 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025029

		b. Secondary causes of hemolytic anemia have been evaluated and alternative etiologies are not the primary cause of the current hemolysis; AND 3. Individual is experiencing one of the following: c. Individual is currently receiving or has previously received corticosteroid therapy for wAIHA and experienced inadequate response to corticosteroids; OR d. Individual is currently receiving or has previously received corticosteroid therapy for wAIHA and relapsed after corticosteroid taper or discontinuation; OR e. Individual is currently receiving or has previously received corticosteroid therapy for wAIHA and is corticosteroid dependent; OR f. Corticosteroids are contraindicated or not tolerated in this individual; AND 4. Nipocalimab is prescribed by or in consultation with a hematologist; AND 5. Nipocalimab will not be used concurrently with another FcRn inhibitor (e.g., efgartigimod, rozanolixizumab) . AUTHORIZATION RENEWAL: 1. Condition improved with treatment as evidenced by ONE or more of the following: a. Hemoglobin increase of greater than or equal to 2 g/dL from pre-treatment baseline; OR b. Achievement or maintenance of hemoglobin greater than or equal to 10 g/dL; OR c. Reduction in markers of hemolysis (LDH, bilirubin, reticulocytosis); OR d. Reduction in transfusion requirements; OR			
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		e. Improvement in fatigue or other clinically significant symptoms; AND 2. Manageable or no side effects; AND 3. Individual will not be receiving concurrent chronic IVIG (does not include IVIG administered as rescue therapy) or other FcRn inhibitor (e.g., efgartigimod, rozanolixizumab).			
Ocrelizumab (e.g., Ocrevus) and Ocrelizumab with Hyaluronidase (e.g., Ocrevus Zunovo)	2017021	Coverage criteria updated for IV formulation. - Individual is 10 years of age or older (Ocrevus, 2026); AND - Individual has a diagnosis of primary progressive multiple sclerosis (PPMS); OR - Individual has a diagnosis of one of the following forms of relapsing multiple sclerosis (MS): - Relapsing-remitting multiple sclerosis (MS); OR - Active secondary progressive MS; OR - Clinically isolated syndrome of MS; AND - Individual is not receiving any of the below drugs concurrently: - Disease modifying agents: interferon beta preparations, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, ponesimod, ozanimod, teriflunomide; OR - Targeted B-cell agents: rituximab, belimumab, ofatumumab, ublituximab; OR - Lymphocyte blockers: alemtuzumab or mitoxantrone. Authorization renewal criteria updated for IV and SC formulations. - Condition stable or improved with treatment; AND - Manageable or no side effects; AND - Individual is not receiving any of the below drugs concurrently:	No	December 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017021

		a. Disease modifying agents: interferon beta preparations, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, ponesimod, ozanimod, teriflunomide; OR b. Targeted B-cell agents: rituximab, belimumab, ofatumumab, ublituximab; OR c. Lymphocyte blockers: alemtuzumab or mitoxantrone.			
Inebilizumab-cdon (e.g., Uplizna)	2020016	Coverage criteria added for myasthenia gravis. INITIAL APPROVAL: 1. Individual is 18 years of age or older (Uplizna, 2025); AND 2. Individual has an established diagnosis of generalized myasthenia gravis (gMG) with a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV confirmed by a neurologist MD/DO; AND 3. Individual has impaired activities of daily living defined as a Myasthenia Gravis-Specific Activities of Daily Living (MG-ADL) scale total score greater than or equal to 6 at initiation; AND 4. Individual is anti-AChR or anti-MuSK antibody positive (Uplizna, 2025); AND 5. Individual has inadequate treatment response, intolerance, or contraindication to an acetylcholinesterase inhibitor (Bird, 2024); AND 6. Individual has inadequate treatment response to a 6-month trial with at least one or more of the following immunosuppressants: Azathioprine, Cyclosporine, Mycophenolate mofetil, Tacrolimus, Glucocorticoids, Methotrexate, Cyclophosphamide; OR 7. Individual has a documented intolerance or contraindication to all listed immunosuppressive therapies (e.g., azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, glucocorticoids, methotrexate, or cyclophosphamide); OR	No	December 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=20200196

		8. Individual is on a stable dose of one or more immunosuppressive therapies (e.g., azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, glucocorticoids, methotrexate, or cyclophosphamide) and has required four or more rescue or bridge therapies [e.g., intravenous immune globulin (IVIG) or therapeutic plasma exchange] within 12 months (Alhaidar, 2022); AND 9. Individual will not be receiving concurrent chronic IVIG (does not include IVIG administered as rescue therapy) or other gMG biologic agent (e.g., eculizumab, ravulizumab, rituximab, nipocalimab, satralizumab, rozanolixizumab-noli, zilucoplan) in combination with inebilizumab. AUTHORIZATION RENEWAL: 1. Condition improved with treatment as evidenced by a decrease of 2 points in MG-ADL total score from pre-treatment baseline value; AND 2. Manageable or no side effects; AND 3. Individual will not be receiving concurrent chronic IVIG (does not include IVIG administered as rescue therapy) or other gMG biologic agent in combination with inebilizumab. Authorization renewal criteria updated for NMOSD and IGG4-RD. AUTHORIZATION RENEWAL: 1. Condition stable improved with treatment; AND 2. Manageable or no side effects.			
Gene Therapies for Hemophilia [Etranacogene dezaparvovec-drlb (e.g., Hemgenix)]	2023017	Coverage criteria updated for clarification of hemophilia B. 1. Individual is 18 years of age or older; AND 2. Individual was assigned male at birth; AND	No	December 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023017

		3. Individual has -moderate-to-severe hemophilia B as defined by a plasma Factor IX (FIX) activity level less than or equal to 5%; AND 4. Individual meets one of the following: a. Individual is currently receiving Factor IX (FIX) prophylaxis (Hemgenix, 2022); OR b. Individual is using on demand therapy and has a documented history of at least 12 bleeding episodes over the previous year; AND 5. Individual meets one of the following: a. Current or historical life-threatening hemorrhage (Hemgenix, 2022); OR b. Repeated, serious spontaneous bleeding episodes (Hemgenix, 2022); AND 6. Individual does not have a history of FIX inhibitors or a positive screen result of greater than or equal to 0.6 Bethesda Units (BU) using the Nijmegen-Bethesda assay; AND 7. Individual is HIV negative or has a controlled HIV infection; AND 8. Absence of active infection at time of scheduled infusion; AND 9. Individual does not have a history of receiving gene therapy or under consideration for treatment for another gene therapy for hemophilia B; AND 10. Hemgenix is being prescribed by or in consultation with a hematologist or a prescriber who specializes in hemophilia B and is being administered by or in consultation with a Hemophilia Treatment Center (HTC) and post-administration monitoring per the manufacturer recommendations is planned by or in consultation with an HTC.			
Denosumab (e.g., Xgeva and Prolia)	2017009	Preferred/non-preferred products list added effective January 1, 2027. Select products (e.g., Stoboclo/Osenvelt, Bilydos/Bilprevda, Enoby/Xtrenbo) are preferred	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017009

		where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product. Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5167, Enoby/Xtrenbo, Denosumab-qbde Q5162, Bildyos/Bilprevda, Denosumab-nxxp Q5157, Stoboclo/Osenvelt, Denosumab-bmwo Non-preferred Products: <u>HCPCS, Brand Name, Generic Name</u> J0897, Prolia/Xgeva, Denosumab Q5136, Jubbonti/Wyost, Denosumab-bbdz Q5158, Bomynta/Conexxence, Denosumab-bnht Q5159, Ospomyv/Xbryk, Denosumab-dssb Q5161, Aukelso/Bosaya, Denosumab-kyqq Q5165, Oziltus, Denosumab-mobz Q5166, Osvyrti/Jubereq, Denosumab-desu Q5171, Boncresa, Denosumab-mobz Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual had a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered			
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		unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested. Prior Approval statement has been added. Effective January 1, 2027, Prior Approval is required for Denosumab (e.g., Xgeva and Prolia) and Biosimilars. Coverage criteria updated. <u>ONCOLOGY SUPPORTIVE INDICATIONS (XGEVA formulation):</u> <u>INITIAL APPROVAL:</u> 1. Use of this medication in supportive care of oncology patient is listed in one of the following sources: - FDA label, in accordance with the specific indication; OR - 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®); AND 2. 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. <u>AUTHORIZATION RENEWAL:</u>			
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		1. Manageable or no side effects; AND 2. Condition stable or improved with treatment. . <u>NON-ONCOLOGY INDICATIONS (PROLIA formulation):</u> <u>EXISTING OSTEOPOROSIS OR OSTEOPENIA</u> <u>INITIAL APPROVAL:</u> 1. Individual has a diagnosis of osteoporosis or osteopenia; AND 2. Individual is an adult and will be using denosumab for one of the following: a. Treatment of osteoporosis or osteopenia in postmenopausal female; OR b. Treatment of osteoporosis or osteopenia in adult male; OR c. Treatment of glucocorticoid-induced osteoporosis and individual is on long-term corticosteroid treatment associated with increased risk of fracture; AND 3. Individual has osteoporosis confirmed by bone mineral density imaging; OR 4. Individual has a clinical diagnosis of osteoporosis based on history of low trauma fracture (fragility fracture); OR 5. Individual has osteopenia confirmed by bone mineral density imaging (a pre-treatment T-score between -1 and -2.5) with either FRAX 10-year fracture probability greater than or equal to 20% or FRAX hip fracture probability greater than or equal to 3%. <u>AUTHORIZATION RENEWAL:</u>			
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		1. Condition stable or improved with treatment; AND 2. Manageable or no acute-phase reaction following prior injection; AND 3. No evidence of hypocalcemia; AND 4. Individual is not currently pregnant; AND 5. Planned injection is at least 6 months since prior denosumab or denosumab biosimilar injection. <u>OSTEOPOROSIS PROPHYLAXIS</u> <u>INITIAL APPROVAL:</u> 1. Individual is a biological male at high risk for bone fractures after receiving androgen deprivation therapy for nonmetastatic prostate cancer; OR 2. Individual is at high risk for bone fractures after receiving adjuvant aromatase inhibitor therapy for breast cancer. <u>AUTHORIZATION RENEWAL:</u> 1. Condition stable or improved with treatment; AND 2. Manageable or no acute-phase reaction following prior injection; AND 3. No evidence of hypocalcemia; AND 4. Individual is not currently pregnant; AND 5. Planned injection is at least 6 months since prior denosumab or denosumab biosimilar injection.			
Alpha-1 Proteinase Inhibitor Therapy (e.g., Aralast, Glassia, Prolastin, and Zemaira)	2017001	Policy transitioned to InterQual® effective December 2, 2026. See specific criteria in InterQual®: https://prod.ds.interqual.com/service/connect/transparency?tid=27b0a724-ca06-4b22-846b-598b8dae52fc	No	December 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017001

Burosumab-twza (e.g., Crysvisa)	2018024	Coverage criteria updated for X-linked hypophosphatemia and hypophosphatemia in tumor-induced osteomalacia. <u>X-LINKED HYPOPHOSPHATEMIA</u> INITIAL APPROVAL: 1. Individual is 6 months of age or older; AND 2. Individual has a diagnosis of x-linked hypophosphatemia confirmed by one of the following: a. PHEX (phosphate regulating endopeptidase homolog X-linked) pathogenic gene mutation – laboratory documentation must be provided (Imel, 2019); OR b. serum fibroblast growth factor 23 (FGF23) level higher than upper limit of normal for the assay laboratory documentation must be provided (NCT02163577, 2019); AND 3. Individual's fasting serum phosphorus level is below age-based normal level (see policy guidelines) – laboratory documentation must be provided (Crysvisa, 2026). Burosumab cannot be initiated if the serum phosphorus is within or above the normal range for age; AND 4. One of the following: a. Individual's epiphyseal plate has not fused (Carpenter, 2018); OR b. Individual's epiphyseal plate has fused AND the individual is experiencing symptoms of XLH (e.g., bone pain, fractures, pseudofractures, limited ambulation)- imaging or radiographic documentation must	No	December 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2018024
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		be provided at time of request (Insogna, 2018); AND 5. Burosumab will not be used in combination with oral phosphate or active vitamin D analogs (Crysvita, 2026); AND 6. Individual does not have severe renal impairment or end stage renal disease defined as a glomerular filtration rate less than 30mL/min (Crysvita, 2026); AND 7. Individual has characteristic biochemical findings consistent with renal phosphate wasting (e.g., low tubular maximum phosphate resorption per glomerular filtration rate (TmP/GFR), elevated fractional excretion of phosphate (FEPO₄), elevated urinary phosphate excretion despite hypophosphatemia). AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND 2. Individual has demonstrated a clinically meaningful response to treatment with burosumab – documentation from the medical record must be provided; AND 3. Burosumab will not be used in combination with oral phosphate or active vitamin D analogs. <u>HYPOPHOSPHATEMIA IN TUMOR-INDUCED OSTEOMALACIA</u> INITIAL APPROVAL: 1. Individual is 2 years of age or older; AND 2. Individual has been diagnosed with hypophosphatemia in tumor-induced osteomalacia; AND			
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		3. Individual has a phosphaturic mesenchymal tumor that cannot be curatively resected or cannot be located (Crysvita, 2026); AND 4. Individual's FGF23 level is higher than upper limit of normal for the assay (laboratory documentation must be provided) (NCT02304367, 2020); AND 5. Individual's fasting serum phosphorus is below the normal range for age (see policy guidelines) (laboratory documentation must be provided); AND 6. Individual has characteristic biochemical findings consistent with renal phosphate wasting (e.g., low tubular maximum phosphate resorption per glomerular filtration rate (TmP/GFR), elevated fractional excretion of phosphate (FEPO₄), elevated urinary phosphate excretion despite hypophosphatemia); AND 7. Burosumab will not be used in combination with oral phosphate or active Vitamin D analogs (Crysvita, 2026); AND 8. Individual does not have severe renal impairment or end stage renal disease defined as a glomerular filtration rate less than 30mL/min (Crysvita, 2026). AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND 2. Individual has demonstrated a clinically meaningful response to treatment with burosumab – documentation from the medical record must be provided; AND 3. Burosumab will not be used in combination with oral phosphate or active vitamin D analogs.			
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Erythropoiesis-Stimulating Agents (ESAs)	2013003	Title changed from Stem Cell Growth Factors, Erythropoiesis-Stimulating Agents (ESAs), Darbepoetin, Epoetin, Methoxy polyethylene glycol (PEG) epoetin-beta to Erythropoiesis-Stimulating Agents (ESAs). Coverage criteria updated. <u>DARBEPOETIN ALFA (E.G., ARANESP)</u> <u>NON-ONCOLOGY INDICATIONS</u> INITIAL APPROVAL: 1. Individual is 1 month of age or older with a diagnosis of chronic kidney disease with or without dialysis; AND 2. Individual's blood pressure is controlled; AND 3. All of the above: a. Hemoglobin < 10 g/dL; AND b. No evidence of occult blood loss or hemolysis; AND c. Folate or B12 deficiencies managed or not present; AND d. Iron deficiency managed or not present AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND 2. Blood pressure is controlled; AND 3. Hemoglobin < 11 g/dL; AND 4. Iron deficiency managed or not present. <u>ONCOLOGY SUPPORTIVE INDICATIONS</u> <u>INITIAL APPROVAL:</u> 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 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2013003
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		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®); AND 2. 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. AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND 2. condition stable or improved with treatment. <u>EPOETIN ALFA (EPOGEN, PROCRIT, AND RETACRIT)</u> <u>NON-ONCOLOGY INDICATIONS</u> INITIAL APPROVAL: 1. Individual is 1 month of age or older with a diagnosis of chronic kidney disease with or without dialysis; OR 2. Individual is 18 years of age or older and is receiving zidovudine (AZT) therapy for human immunodeficiency virus (HIV); OR 3. Individual is 18 years of age or older and is at high risk for perioperative blood loss during elective noncardiac, nonvascular surgery; OR 4. Individual is 18 years of age or older and receives ribavirin-based therapy for chronic hepatitis C virus infection; AND			
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		5. Individual's blood pressure is controlled; AND 6. Individual may be switching from epoetin alfa or an epoetin alfa biosimilar for the same indication with no serious adverse event, significant intolerance, significant side effects, allergic response or continued symptoms or findings after ≥ 2 months of treatment; AND 7. All of the above: - Hemoglobin < 10 g/dL; AND - No evidence of occult blood loss or hemolysis; AND - Folate or B12 deficiencies managed or not present; AND - Iron deficiency managed or not present AUTHORIZATION RENEWAL: - Manageable or no side effects; AND - Blood pressure is controlled; AND - Hemoglobin < 11 g/dL; AND - Iron deficiency managed or not present. <u>ONCOLOGY SUPPORTIVE INDICATIONS</u> <u>INITIAL APPROVAL:</u> - Use of this medication in supportive care of oncology patient is listed in one of the following sources: - FDA label, in accordance with the specific indication; OR - 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			
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		Practice Guidelines in Oncology (NCCN Guidelines®); AND 2. 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. AUTHORIZATION RENEWAL: 1. Manageable or no side effects; AND 2. condition stable or improved with treatment.																									
Risperidone, Long-acting Injectables (e.g., Risperdal Consta, Rykindo, Perseris, Uzedy)	2026012	New policy effective December 2, 2026.	No	December 2, 2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2026012																						
Immune Globulin, Primary and Secondary Immunodeficiencies	1997113	Prior Approval statement has been added. Effective January 1, 2027, Prior Approval is required for all IVIG/SCIG products. Preferred/non-preferred products list updated. Select products are preferred. Preferred Products: <table><thead><tr><th>HCPCS</th><th>Brand Name</th></tr></thead><tbody><tr><td>J1459</td><td>Privigen</td></tr><tr><td>J1561</td><td>Gammaked, Gamunex-C</td></tr><tr><td>J1568</td><td>Octagam</td></tr><tr><td>J1569</td><td>Gammagard</td></tr><tr><td>J1572</td><td>Flebogamma</td></tr><tr><td>J1553</td><td>Yimmugo</td></tr><tr><td>J1551</td><td>Cutaquig</td></tr><tr><td>J1559</td><td>Hizentra</td></tr><tr><td>J1575</td><td>Hyqvia</td></tr><tr><td>J1560</td><td>GamaSTAN</td></tr></tbody></table>	HCPCS	Brand Name	J1459	Privigen	J1561	Gammaked, Gamunex-C	J1568	Octagam	J1569	Gammagard	J1572	Flebogamma	J1553	Yimmugo	J1551	Cutaquig	J1559	Hizentra	J1575	Hyqvia	J1560	GamaSTAN	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1997113
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Immune Globulin, Autoimmune, Rheumatic and Neurologic Indications	2024064	Prior Approval statement has been added. Effective January 1, 2027, Prior Approval is required for all IVIG/SCIG products. Preferred/non-preferred products list updated. Select products are preferred. Preferred Products: <table><tr><th>HCPCS</th><th>Brand Name</th></tr></table>	HCPCS	Brand Name	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024064																						
HCPCS	Brand Name																												

		J1459 Privigen J1561 Gammaked, Gamunex-C J1568 Octagam J1569 Gammagard J1572 Flebogamma J1553 Yimmugo J1551 Cutaquig J1559 Hizentra J1575 Hyqvia J1560 GamaSTAN Non-preferred Products: <table><thead><tr><th>HCPCS</th><th>Brand Name</th></tr></thead><tbody><tr><td>J1554</td><td>Asceniv</td></tr><tr><td></td><td>Carimune</td></tr><tr><td></td><td>Polygam S/D</td></tr><tr><td>J1556</td><td>Bivigam</td></tr><tr><td></td><td>Nanogam</td></tr><tr><td>J1576</td><td>Panzyga</td></tr><tr><td>J1552</td><td>Alyglo</td></tr><tr><td>J1566</td><td>Gammagard S/D, Carimune NF</td></tr><tr><td>J1557</td><td>Gammaplex</td></tr><tr><td>J1555</td><td>Cuvitru</td></tr><tr><td>J1558</td><td>Xembify</td></tr></tbody></table> If the request is for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual has a documented serious adverse event to all preferred products that required medical intervention; AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.	HCPCS	Brand Name	J1554	Asceniv		Carimune		Polygam S/D	J1556	Bivigam		Nanogam	J1576	Panzyga	J1552	Alyglo	J1566	Gammagard S/D, Carimune NF	J1557	Gammaplex	J1555	Cuvitru	J1558	Xembify			
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J1555	Cuvitru																												
J1558	Xembify																												

Immune Globulin-Hematologic, Transplant, Infectious Disease and Miscellaneous Indications	2024065	Prior Approval statement has been added. Effective January 1, 2027, Prior Approval is required for all IVIG/SCIG products. Preferred/non-preferred products list updated. Select products are preferred. Preferred Products: <table><tr><th>HCPCS</th><th>Brand Name</th></tr><tr><td>J1459</td><td>Privigen</td></tr><tr><td>J1561</td><td>Gammaked, Gamunex-C</td></tr><tr><td>J1568</td><td>Octagam</td></tr><tr><td>J1569</td><td>Gammagard</td></tr><tr><td>J1572</td><td>Flebogamma</td></tr><tr><td>J1553</td><td>Yimmugo</td></tr><tr><td>J1551</td><td>Cutaquig</td></tr><tr><td>J1559</td><td>Hizentra</td></tr><tr><td>J1575</td><td>Hyqvia</td></tr><tr><td>J1560</td><td>GamaSTAN</td></tr></table> Non-preferred Products: <table><tr><th>HCPCS</th><th>Brand Name</th></tr><tr><td>J1554</td><td>Asceniv</td></tr><tr><td></td><td>Carimune</td></tr><tr><td></td><td>Polygam S/D</td></tr><tr><td>J1556</td><td>Bivigam</td></tr><tr><td></td><td>Nanogam</td></tr><tr><td>J1576</td><td>Panzyga</td></tr><tr><td>J1552</td><td>Alyglo</td></tr><tr><td>J1566</td><td>Gammagard S/D, Carimune NF</td></tr><tr><td>J1557</td><td>Gammaplex</td></tr><tr><td>J1555</td><td>Cuvitru</td></tr><tr><td>J1558</td><td>Xembify</td></tr></table> If the request is for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual has a documented serious adverse event to all preferred products that required medical intervention; AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting	HCPCS	Brand Name	J1459	Privigen	J1561	Gammaked, Gamunex-C	J1568	Octagam	J1569	Gammagard	J1572	Flebogamma	J1553	Yimmugo	J1551	Cutaquig	J1559	Hizentra	J1575	Hyqvia	J1560	GamaSTAN	HCPCS	Brand Name	J1554	Asceniv		Carimune		Polygam S/D	J1556	Bivigam		Nanogam	J1576	Panzyga	J1552	Alyglo	J1566	Gammagard S/D, Carimune NF	J1557	Gammaplex	J1555	Cuvitru	J1558	Xembify	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024065
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		Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
Non-Bevacizumab Vascular Epithelial Growth Factors for Ophthalmic Use (e.g., Beovu, Byooviz, Cimerli, Eylea, Eylea HD, Lucentis, Pavblu, Vabysmo, Enzeevu, Ahzantive, Yesafili, Opuviz)	2024066	Prior Approval statement updated. Prior Approval is required for Aflibercept (e.g., Eylea), Aflibercept (e.g., Eylea HD), Aflibercept-jbvf (e.g., Yesafili), Ranibizumab-eqrn (e.g., Cimerli), Aflibercept-yszy (e.g., Opuviz), Brolucizumab (e.g., Beovu), Aflibercept-abzv (e.g., Enzeevu), and Aflibercept-mrbb (e.g., Ahzantive). Effective January 1, 2027, Prior Approval is required for all Non-Bevacizumab Vascular Epithelial Growth Factors for Ophthalmic Use. Preferred/non-preferred products list updated. Select products (e.g., Byooviz, Cimerli, Eylea, Eylea HD, Lucentis, Pavblu, Vabysmo) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.” Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5124, Byooviz, Ranibizumab-nuna Q5128, Cimerli, Ranibizumab-eqrn	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024066

		J0178, Eylea, Aflibercept J0177, Eylea HD, Aflibercept J2778, Lucentis, Ranibizumab Q5147, Pavblu, Aflibercept-ayyh J2777, Vabysmo, Faricimab-svoa Non-Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5150, Ahzantive, Aflibercept-mrbp J0179, Beovu, Brolucizumab-dblp Q5149, Enzeevu, Aflibercept-abzv Q5153, Opuviz, Aflibercept-yszy Q5155, Yesafili, Aflibercept-jbvf Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual has a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
Rituximab (e.g., Rituxan) and Biosimilars and Rituximab/Hyaluronidase (e.g., Rituxan Hycela) –	2006016	Preferred/non-preferred products list updated. Select products (e.g., Riabni, Ruxience) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2006016

Oncologic Indications		product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA's rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product. Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5123, Riabni, Rituximab arrx Q5119, Ruxience, Rituximab Non-preferred Products: <u>HCPCS, Brand Name, Generic Name</u> J9310, J9312, Rituxan, Rituximab Q5115, Truxima, Rituximab abbs Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual had a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
Rituximab (e.g., Rituxan) and Biosimilars – Non-	2021034	Preferred/non-preferred products list updated.	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021034

Oncologic Indications		Select products (e.g., Riabni, Ruxience) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product. Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5123, Riabni, Rituximab arrx Q5119, Ruxience, Rituximab Non-preferred Products: <u>HCPCS, Brand Name, Generic Name</u> J9310, J9312, Rituxan, Rituximab Q5115, Truxima, Rituximab abbs Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 3. The individual had a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 4. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product			
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		has the FDA approved indication that is requested.			
Infliximab (e.g., Remicade and Unbranded Infliximab) and Biosimilars	1998161	Preferred/non-preferred products list updated. Select products [Infliximab (e.g., Remicade and Unbranded Infliximab) and Infliximab (e.g., Inflectra, Avsola)] are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.” Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5121, Avsola, Infliximab-axxq J1745, Remicade and Unbranded Infliximab, Infliximab Q5104, Renflexis, Infliximab-abda Non-preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5103, Inflectra, Infliximab-dyyb Q5109, Ixifi, Infliximab-qbtX Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual has a documented serious adverse event to all preferred products that required medical intervention; AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1998161

		provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
Trastuzumab (e.g., Herceptin) and Biosimilars and Trastuzumab/Hyaluronidase-oysk (e.g., Herceptin Hylecta)	1998158	Preferred/non-preferred products list updated. Select products (e.g., Ontruzant, Ogivri, and Trazimera) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.” Preferred Products: <u>HPCPS, Brand Name, Generic Name</u> Q5114, Ogivri, Trastuzumab dkst Q5112, Ontruzant, Trastuzumab dttb Q5116, Trazimera, Trastuzumab qyyp Non-Preferred Products: <u>HPCPS, Brand Name, Generic Name</u> J9355, Herceptin, Trastuzumab J9356, Herceptin Hylecta, Trastuzumab and hyaluronidase oysk Q5146, Hercessi, Trastuzumab-strf Q5113, Herzuma, Trastuzumab pkrb Q5117, Kanjinti, Trastuzumab anns Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued.	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1998158

		If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual has a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
Bevacizumab (e.g., Avastin) and Biosimilars for Non-Oncologic and Non-Ophthalmologic Indications	2023014	Preferred/non-preferred products list updated. Select products (e.g., Mvasi and Vegzelma) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.” Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5107, Mvasi, Bevacizumab awwb Q5129, Vegzelma, Bevacizumab-adcd Non-Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5126, Alymsys, Bevacizumab-maly J9035, Avastin, Bevacizumab N/A, Avzivi, Bevacizumab-tjnj	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023014

		Q5160, Jobevne, Bevacizumab-nwgd Q5118, Zirabev, Bevacizumab bvzr Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual had a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA) OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
Bevacizumab (e.g., Avastin) and Biosimilars for Oncologic Indications	2017006	Preferred/non-preferred products list updated. Select products (e.g., Mvasi and Vegzelma) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.” Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5107, Mvasi, Bevacizumab awwb	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017006

		Q5129, Vegzelma, Bevacizumab-adcd Non-Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5126, Alymsys, Bevacizumab-maly J9035, Avastin, Bevacizumab N/A, Avzivi, Bevacizumab-tnjn Q5160, Jobevne, Bevacizumab-nwgd Q5118, Zirabev, Bevacizumab bvzr Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 3. The individual had a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA) OR 4. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
Bevacizumab (e.g., Avastin) and Biosimilars for Ophthalmic Use	2024021	Prior Approval statement added to policy. Prior Approval is required for Bevacizumab (e.g., Avastin) and Biosimilars. Preferred/non-preferred products list added to policy. Select products (e.g., Mvasi and Vegzelma) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024021

		United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.” Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5107, Mvasi, Bevacizumab awwb Q5129, Vegzelma, Bevacizumab-adcd Non-Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5126, Alymsys, Bevacizumab-maly J9035, Avastin, Bevacizumab N/A, Avzivi, Bevacizumab-tjnj Q5160, Jobevne, Bevacizumab-nwgd Q5118, Zirabev, Bevacizumab bvzr Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 5. The individual had a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA) OR 6. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
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Tocilizumab (e.g., Actemra) and Biosimilars	2020022	Preferred/non-preferred products list updated. Select products (e.g., Actemra, Avtozma, Tofidence, Tyenne) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.” Preferred Products: <table><tr><td>HCPCS</td><td>Brand Name</td><td>Generic Name</td></tr><tr><td>Q5156</td><td>Avtozma</td><td>Tocilizumab-anoh</td></tr><tr><td>Q5135</td><td>Tyenne</td><td>Tocilizumab-aazg</td></tr></table> Non-Preferred Products: <table><tr><td>HCPCS</td><td>Brand Name</td><td>Generic Name</td></tr><tr><td>J3262</td><td>Actemra</td><td>Tocilizumab</td></tr><tr><td>Q5133</td><td>Tofidence</td><td>Tocilizumab- bavi</td></tr></table> If the request is for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual has a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product	HCPCS	Brand Name	Generic Name	Q5156	Avtozma	Tocilizumab-anoh	Q5135	Tyenne	Tocilizumab-aazg	HCPCS	Brand Name	Generic Name	J3262	Actemra	Tocilizumab	Q5133	Tofidence	Tocilizumab- bavi	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2020022
HCPCS	Brand Name	Generic Name																					
Q5156	Avtozma	Tocilizumab-anoh																					
Q5135	Tyenne	Tocilizumab-aazg																					
HCPCS	Brand Name	Generic Name																					
J3262	Actemra	Tocilizumab																					
Q5133	Tofidence	Tocilizumab- bavi																					

		has the FDA approved indication that is requested.			
Ustekinumab (e.g., Stelara) and Biosimilars	2021028	Preferred/non-preferred products list updated. Select products (e.g., Pyzchiva SC/IV, Selarsdi, Selarsdi SC/IV and Yesintek SC/IV, Steqeyma SC/IV) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.”. 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 Q5099, Steqeyma SC, Ustekinumab-stba Q5099, Steqeyma IV, Ustekinumab-stba 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 Q999, Otulfi SC, Ustekinumab-aaaz Q9999, Otulfi IV, Ustekinumab-aaaz J3357, Stelara SC, Ustekinumab J3358, Stelara IV, Ustekinumab Q5164, Starjemza SC, Ustekinumab-hmny Q5164, Starjemza IV, Ustekinumab-hmny Q5137, Wezlana SC, Ustekinumab-auub Q5138, Wezlana IV, Ustekinumab-auub	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021028

		Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual has a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA approved indication that is requested, and the requested non-preferred product has the FDA approved indication that is requested.			
White Blood Cell Growth Factors (Colony Stimulating Factors)	2021024	Preferred/non-preferred products list updated. Select products (e.g., Zarxio, Nivestym, Fulphila, Udenyca and Udenyca Onbody) are preferred where there is an FDA approved indication for the biosimilar product and for all off-label uses of the reference product. According to the United States FDA “a biosimilar is a biological product that has no clinically meaningful differences from the existing FDA-approved reference product. All biosimilar products meet the FDA’s rigorous standards for approval for the indications described in the product labeling. Once a biosimilar has been approved by the FDA, the safety and effectiveness of these products have been established, just as they have been for the reference product.” Preferred Products: <u>HPCPS, Brand Name, Generic Name</u> Q5108, Fulphila, Pegfilgrastim-jmdb Q5110, Nivestym, Filgrastim-aafi Q5101, Zarxio, Filgrastim-sndz	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021024

		Q5111, Udenyca, Pegfilgrastim-cbqv Q5111, Udenyca Onbody, Pegfilgrastim-cbqv Non-Preferred Products: <u>HCPCS, Brand Name, Generic Name</u> Q5130, Fylnetra, Pegfilgrastim-pbbk J1447, Granix, Tbo-filgrastim J2820, Leukine, Sargramostim J1442, Neupogen, Filgrastim J2506, Neulasta, Pegfilgrastim J2506, Neulasta OnPro, Pegfilgrastim Q5148, Nypozi, Filgrastim-txid Q5122, Nyvepria, Pegfilgrastim-apgf Q5125, Releuko, Filgrastim-ayow J1449, Rolvedon, Eflapegrastim-xnst J9361, Ryzneuta, Efbemalenograstim alfa-vuxw Q5127, Stimufend, Pegfilgrastim-fpgk Q5120, Ziextenzo, Pegfilgrastim-bmez Q5169, Armlupeg, Pegfilgrastim-unne J3590, Filkri, Filgrastim-laha Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued. If an exception request is submitted for a non-preferred product, one of the following criteria must be met for the non-preferred product to be covered: 1. The individual has a documented serious adverse event to all preferred products that required medical intervention AND the prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form for each event (the prescriber must provide a copy of the completed MedWatch form. Authorizations will not be considered unless the form is completed and submitted to the FDA); OR 2. None of the preferred products have an FDA-approved indication that is requested, and the requested non-preferred products has the FDA approved indication that is requested.			
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Pembrolizumab (e.g., Keytruda)	2019005	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Pembrolizumab (e.g., Keytruda).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2019005
Pembrolizumab and berahyaluronidase (e.g., keytruda Qlex)	2026003	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Pembrolizumab and Berahyaluronidase (e.g., Keytruda Qlex).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2026003
Nivolumab (e.g., Opdivo)	2016005	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Nivolumab (e.g., Opdivo).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2016005
Nivolumab and hyaluronidase (e.g., Opdivo Qvantig)	2025024	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Nivolumab and hyaluronidase (e.g., Opdivo Qvantig).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025024
Daratumumab (e.g., Darzalex) and Daratumumab and hyaluronidase (e.g., Darzalex Faspro)	2016012	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Daratumumab (e.g., Darzalex) and Daratumumab and hyaluronidase (e.g., Darzalex Faspro).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2016012
Brentuximab vedotin (e.g., Adcetris)	2017008	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Brentuximab vedotin (e.g., Adcetris).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017008
Tarlatamab (e.g., Imdelltra)	2024070	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Tarlatamab (e.g., Imdelltra).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024070
Ramucirumab (e.g., Cyramza)	2017016	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Ramucirumab (e.g., Cyramza).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017016

Panitumumab (e.g., Vecitibix)	2017024	Prior Approval statement added. Effective January 1, 2027, Prior Approval is required for Panitumumab (e.g., Vecitibix).	Yes	January 1, 2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017024
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