

PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMEUREMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Beremagene Geperpavec-svdt (e.g., Vyjuvek)	2023047	Effective 2/1/2026, Beremagene Geperpavec-svdt (e.g., Vyjuvek) will be archived. Beremagene geperpavec-svdt will be moved to the Self-Administered Medication policy, 2020005.	No	2/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023047
Pertuzumab (e.g., Perjeta)	2014014	<p>Coverage criteria updated.</p> <p>FDA labeled indication criteria updated to include individuals age 18 years of age or older for HER2-positive breast cancer/metastatic breast cancer. Off-label indications updated to include appendiceal neoplasms and cancers.</p> <p><u>FDA Labeled Indications:</u></p> <p><u>HER2-POSITIVE METASTATIC BREAST CANCER (MBC)</u></p> <p>STANDARD REVIEW:</p> <ol style="list-style-type: none"> 1. Individual is 18 years of age or older (Perjeta, 2025); AND 2. Individual has a diagnosis of HER2-positive (see policy guidelines) metastatic breast cancer (MBC) (Perjeta, 2025); AND 3. Individual has not received prior anti-HER2 therapy or chemotherapy for metastatic disease (Perjeta, 2025); AND 4. Pertuzumab (e.g., Perjeta) will be used in combination with trastuzumab and docetaxel (Perjeta, 2025); AND 5. Pertuzumab (e.g., Perjeta) will not be used for any of the following conditions: <ol style="list-style-type: none"> a. HER2-positive: <ol style="list-style-type: none"> i. Gastric cancer; OR ii. Non-small cell lung cancer; OR iv. Ovarian cancer; OR v. Gastro-esophageal junction cancer; OR b. Her2-negative cancers. <p><u>HER2-POSITIVE BREAST CANCER</u></p>	No	2/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2014014

		<p>STANDARD REVIEW:</p> <ol style="list-style-type: none"> 1. Individual is 18 years of age or older (Perjeta, 2025); AND 2. Individual has a diagnosis of HER2-positive, locally advanced, inflammatory, or early-stage breast cancer (Perjeta, 2025); AND 3. Breast cancer is either: <ol style="list-style-type: none"> a. Greater than 2 cm in diameter; OR b. Node positive; AND 4. Pertuzumab (e.g., Perjeta) will be used in combination with trastuzumab and chemotherapy as neoadjuvant treatment; OR 5. Individual has a diagnosis of HER2-positive early breast cancer at high risk of recurrence (see policy guidelines for definition of high risk of recurrence); AND 6. Pertuzumab (e.g., Perjeta) will be used in combination with trastuzumab and chemotherapy; AND 7. Pertuzumab (e.g., Perjeta) will not be used for any of the following conditions: <ol style="list-style-type: none"> b. HER2-positive: <ol style="list-style-type: none"> i. Gastric cancer; OR ii. Non-small cell lung cancer; OR iii. Ovarian cancer; OR iv. Gastro-esophageal junction cancer; OR c. Her2-negative cancers. <p><u>Off-Label Indications:</u></p> <p>STANDARD REVIEW:</p> <ol style="list-style-type: none"> 1. Biliary Tract Cancers: <ol style="list-style-type: none"> a. Gallbladder Cancer (NCCN 2A); OR b. Intrahepatic Cholangiocarcinoma (NCCN 2 A); OR c. Extrahepatic Cholangiocarcinoma (NCCN 2A); OR 2. Head and Neck Cancers: <ol style="list-style-type: none"> a. Salivary Gland Tumors (NCCN 2A); OR 			
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		<p>3. Breast Cancer:</p> <ul style="list-style-type: none"> a. Invasive Breast Cancer (NCCN 1 and 2A); OR b. Special consideration: Inflammatory Breast Cancer (NCCN 1 and 2A); OR <p>4. Central Nervous System Cancers:</p> <ul style="list-style-type: none"> a. Limited Brain Metastases (NCCN 2A); OR b. Extensive Brain Metastases (NCCN 2A); OR <p>5. Appendiceal Neoplasms and Cancers (NCCN 2A); OR</p> <p>6. Colon Cancer (NCCN 2A); OR</p> <p>7. Rectal Cancer (NCCN 2A).</p>			
Maximum Dosage and Frequency for Medical Benefit Drugs	2025031	<p>Coverage criteria updated.</p> <p>Maximum allowed quantities by HCPCS units list updated.</p> <p><u>Maximum Allowed Quantities by HCPCS Units</u></p> <p>Generic name (brand name) -- HCPCS code-- maximum billing units (quantity/unit)- minimum frequency</p> <p>Tofersen (Qalsody)-- J1304--100 billing units (1 mg per unit)- every 14 days</p> <p>Alemtuzumab (Lemtrada)-- J0202-- 12 billing units (1 mg per unit)- daily for 5 days per year</p> <p>Efgartigimod alfa and hyaluronidase (Vyvgart Hytrulo)-- J9334-- 504 billing units (2 mg per unit)- once weekly</p> <p>Efgartigimod alfa (Vyvgart)-- J9332 -- 600 billing units (2 mg per unit)- once weekly for up to 4 doses per cycle, cycles at least 28 days apart</p> <p>Nexvazyme (Avalglucosidase alfa)-- J0219-- 700 billing units (4 mg per unit)- once every two weeks</p> <p>Vutrisiran (Amvuttra)-- J0225-- 25 billing units (1 mg per unit)- once every 3 months</p>	No	2/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025031

		Patisiran (Onpattro)-- J0222-- 300 billing units (0.1 mg per unit)- once every 3 weeks			
Foscarbidopa with foslevodopa (e.g., Vyalev)	2025036	New policy developed for the treatment of advanced Parkinson's disease with effective date of 2/1/2026.	No	2/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025036
Linvoseltamab-gcpt (e.g., Lynozyfic)	2025037	New policy developed for the treatment of relapsed or refractory multiple myeloma with effective date of 2/1/2026.	No	2/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025037
Self-Administered Medication	2020005	Coverage criteria updated. Beremagene Geperpavec-svdt (e.g., Vyjuvek) added to Self-Administered Medication list.	No	2/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2020005