

PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMENDMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Moxetumomab pasudotox-tdfk (e.g., Lumoxiti)	2021008	Effective 4/15/2026, this policy will be archived.	No	4/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021008
Enfortumab Vedotin-ejfv (e.g., Padcev)	2021002	<p>FDA Labeled Indications initial approval coverage criteria updated. FDA Labeled Indications and Off-label Indications continuation criteria added.</p> <p>FDA Labeled Indications:</p> <p>INITIAL APPROVAL:</p> <ol style="list-style-type: none"> 1. Individual is diagnosed with locally advanced or metastatic urothelial cancer (Padcev, 2023; Roseberg, 2019; Powles, 2021; NCCN 1 and 2A); AND 2. Individual is an adult; AND 3. Individual is diagnosed with muscle invasive bladder cancer that is ineligible for cisplatin-containing chemotherapy and will be using enfortumab vedotin in combination with pembrolizumab or pembrolizumab and berahyaluronidase alfa as neoadjuvant treatment continued after cystectomy as adjuvant treatment (Padcev, 2025); OR 4. Individual is diagnosed with locally advanced or metastatic urothelial cancer and will be using enfortumab vedotin in combination with pembrolizumab or pembrolizumab with berahyaluronidase (Padcev, 2025); OR 5. Individual has a diagnosis of locally advanced or metastatic urothelial cancer and will be using enfortumab vedotin as a single agent in the following circumstances: <ol style="list-style-type: none"> a. Individual has previously received platinum containing chemotherapy and PD-1 or PD-L1 inhibitor (Padcev, 2025); OR b. Individual is ineligible for cisplatin-containing chemotherapy and have previously received one or more 	No	4/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021002

		<p>prior lines of therapy (Padcev, 2025)</p> <p>FDA Labeled Indications and Off-label Indications continuation criteria:</p> <p>CONTINUATION OF THERAPY</p> <ol style="list-style-type: none"> 1. Individual continues to meet the initial approval criteria; AND 2. Documentation indicating disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread. 			
Romidepsin (e.g., Istodax)	2021009	<p>Off-label Indications continuation criteria added.</p> <p>CONTINUATION OF THERAPY:</p> <ol style="list-style-type: none"> 1. Individual continues to meet the initial approval criteria; AND 2. Tumor response with stabilization of disease or decrease in size of tumor or tumor spread (Istodax, 2021); AND 3. Individual is not experiencing unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: hematological abnormalities (e.g., neutropenia, anemia, leucopenia, thrombocytopenia, etc.), severe infections, severe tumor lysis syndrome, and ECG T-wave changes (Istodax, 2021). 	No	4/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021009
Naxitamab-gqgk (e.g., Danyelza)	2021017	<p>Off-label Indications initial approval and continuation criteria added.</p> <p>INITIAL APPROVAL:</p> <ol style="list-style-type: none"> 1. Neuroblastoma: <ol style="list-style-type: none"> a. Chemoimmunotherapy in combination with temozolomide, irinotecan, and sargramostim following induction for high-risk disease with (NCCN 2A): <ol style="list-style-type: none"> i. Minor response or stable disease (as bridging 	No	4/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021017

		<p>therapy to standard consolidation); OR</p> <p>b. Chemoimmunotherapy in combination with temozolomide, irinotecan, and sargramostim in individuals with progressive disease following consolidation for high-risk disease (NCCN 2A).</p> <p>CONTINUATION OF THERAPY:</p> <ol style="list-style-type: none"> 1. Individual continues to meet initial criteria; AND 2. Individual continues to have clinical benefit on naxitamab-gqqk as demonstrated by tumor response or lack of disease progression. 			
Reslizumab (e.g., Cinqair)	2018008	<p>Continuation coverage criteria updated.</p> <p>CONTINUATION OF THERAPY:</p> <ol style="list-style-type: none"> 1. Individual continues to meet the initial approval criteria; AND 2. Treatment with reslizumab has resulted in clinical improvement as documented by one or more of the following: <ol style="list-style-type: none"> a. Decreased utilization of rescue medications; or b. Decreased frequency of exacerbations (defined as worsening of asthma that requires an increase in ICS dose or treatment with systemic corticosteroids), hospitalizations, and/or ER/urgent visits; OR c. Increase in predicted FEV1 from pretreatment baseline 	No	4/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2018008
Obecabtagene autoleucel (e.g., Aucatzyl)	2025004	<p>Coverage criteria updated.</p> <ol style="list-style-type: none"> 1. Individual is 18 years of age or older (Aucatzyl, 2024; Roddie, 2024); AND 2. Individual has a confirmed diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL) (Aucatzyl, 2024; NCCN 2A) with confirmed CD19 tumor expression; AND 	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025004

		<ol style="list-style-type: none">3. Individual has had two or more prior lines of systemic therapy (Roddie, 2024); OR4. Individual is relapsed or refractory at least greater than 3 months after allogeneic stem cell transplantation (SCT) (Aucatzyl, 2024; Roddie, 2024); AND5. Individual has one of the following (NCCN 2A):<ol style="list-style-type: none">a. Philadelphia chromosome positive (Ph+) ALL, confirmation of trial and inadequate response or intolerance to at least two tyrosine kinase inhibitor (TKI) therapies, or failed one line or second generation TKI, or TKI therapy is contraindicated; ORb. Individual has Philadelphia chromosome-negative (Ph-) ALL;; AND6. Individual has adequate renal, hepatic, pulmonary, and cardiac function (Roddie, 2024); AND7. Individual has not received prior treatment with CAR-T cell therapy or other genetically modified T-cell therapy (NCT04404660); AND8. Individual has morphologic tumor involvement (greater than or equal to 5% blasts) in bone marrow at screening (NCT04404660); AND9. Individual has an ECOG performance status of 0 or 1 (NCT04404660); AND10. Individual does not have any of the following conditions:<ol style="list-style-type: none">a. Isolated extra medullary disease (Aucatzyl, 2024; Roddie, 2024); ORb. Active graft versus host disease (GVHD) (Aucatzyl, 2024); ORc. Prior or present central nervous system (CNS) disorders (i.e., white blood cell count greater than or equal to 5 cells/μL in cerebrospinal fluid with presence of lymphoblasts Presence of CNS-3 disease or CNS-2 disease with neurological changes (Roddie, 2024); OR			
--	--	--	--	--	--

		<p>d. History or presence of any CNS disorder such as a seizure disorder, cerebrovascular ischemia/hemorrhage, dementia, cerebellar disease, or any autoimmune disease with CNS involvement (Roddie, 2024); OR</p> <p>e. Received prior stem cell transplant less than 3 months prior to Obecabtagene autoleucel (e.g., Aucatzyl) infusion. (Roddie, 2024)</p>			
Bevacizumab (e.g., Avastin) for Oncologic Indications	2017006	<p>Preferred/non-preferred products language updated.</p> <p>Select products (e.g., Mvasi and Zirabev) 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.”</p> <p>Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> Q5107, Mvasi, Bevacizumab awwb Q5118, Zirabev, Bevacizumab bvzr</p> <p>Non-Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> J9035, Avastin, Bevacizumab Q5126, Almysys, Bevacizumab-maly Q5129, Vegzelma, Bevacizumab-adcd J9999, Jobevne, Bevacizumab-nwgd N/A, Avzivi, Bevacizumab-trjn</p> <p>Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued.</p>	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2017006

		<p>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:</p> <ol style="list-style-type: none"> 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) for Non-Oncologic and Non-Ophthalmologic Indications	2023014	<p>Preferred/non-preferred products language updated.</p> <p>Select products (e.g., Mvasi and Zirabev) 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.”</p> <p>Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> Q5107, Mvasi, Bevacizumab awwb Q5118, Zirabev, Bevacizumab bvzr</p> <p>Non-Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u></p>	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2023014

		<p>Q5126, Almysys, Bevacizumab-maly J9035, Avastin, Bevacizumab N/A, Avzivi, Bevacizumab-tjnj J9999, Jobevne, Bevacizumab-nwgd Q5129, Vegzelma, Bevacizumab-adcd</p> <p>Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued.</p> <p>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:</p> <ol style="list-style-type: none"> 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. 			
Infliximab (e.g., Remicade and Unbranded Infliximab)	1998161	<p>Preferred/non-preferred products language updated.</p> <p>Select products [Infliximab (e.g., Remicade and Unbranded Infliximab) and Infliximab (e.g., Inflectra)] 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.”</p>	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1998161

		<p>Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> Q5121, Avsola, Infliximab-axxq Q5103, Inflectra, Infliximab-dyyb J1745, Remicade and Unbranded Infliximab, Infliximab</p> <p>Non-preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> Q5109, Ixifi, Infliximab-qbtx Q5104, Renflexis, Infliximab-abda</p> <p>Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued.</p> <p>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:</p> <ol style="list-style-type: none"> 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 - Non-Oncologic	2021034	<p>Preferred/non-preferred products language updated.</p> <p>Select products (e.g., Truxima and 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</p>	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021034

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

Q5123, Riabni, Rituximab arrx
Q5115, Truxima, Rituximab abbs

Non-preferred Products:

HCPCS, Brand Name, Generic Name

J9310, J9312, Rituxan, Rituximab
Q5119, Ruxience, Rituximab pvvr

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.

<p>Rituximab (e.g., Rituxan) and Biosimilars - Oncologic</p>	<p>2006016</p>	<p>Preferred/non-preferred products language updated.</p> <p>Select products (e.g., Ruxience and Truxima) 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."</p> <p>Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> Q5123, Riabni, Rituximab arrx Q5115, Truxima, Rituximab abbs</p> <p>Non-preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> J9310,J9312, Rituxan, Rituximab J9311, Rituxan Hycela, Rituximab and hyaluronidase Q5119, Ruxience, Rituximab pvvr</p> <p>Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued.</p> <p>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:</p> <ol style="list-style-type: none"> 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 	<p>Yes</p>	<p>5/15/2026</p>	<p>https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2006016</p>
--	----------------	--	------------	------------------	--

		<p>unless the form is completed and submitted to the FDA); OR</p> <p>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.</p>			
Trastuzumab (e.g., Herceptin) and Trastuzumab/Hyaluronidase-oysk (e.g., Herceptin Hylecta)	1998158	<p>Preferred/non-preferred products language updated.</p> <p>Select products (e.g., Ontruzant, Ogivri, and Kanijinti) 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.”</p> <p>Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> Q5117, Kanjinti, Trastuzumab anna Q5114, Ogivri, Trastuzumab dkst Q5112, Ontruzant, Trastuzumab dttb</p> <p>Non-Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u> J9355, Herceptin, Trastuzumab J9356, Herceptin Hylecta, Trastuzumab and hyaluronidase oysk Q5146, Hercessi, Trastuzumab-strf Q5113, Herzuma, Trastuzumab pkrb Q5116, Trazimera, Trastuzumab qyyp</p> <p>Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued.</p>	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1998158

		<p>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:</p> <ol style="list-style-type: none"> 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. 			
<p>Non-bevacizumab vascular Epithelial Growth Factors for Ophthalmic use (e.g., Beovu, Byooviz, Cimerli, Eylea, Eylea HD, Lucentis, Pavblu, Vabysmo, Enzeevu, Ahzantive)</p>	2024066	<p>Preferred/non-preferred products language updated.</p> <p>Select products (e.g., Byooviz, Cimerli, 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.”</p> <p>Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u></p> <p>Q5124, Byooviz, Ranibizumab-nuna J2778, Lucentis, Ranibizumab Q5147, Pavblu, Afilbercept-ayyh J2777, Vabysmo, Faricimab-svoa</p>	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=20240066

		<p>Non-Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u></p> <p>Q5150, Ahzantive, Aflibercept-mrbb J0179, Beovu, Brolucizumab-dbll Q5128, Cimerli, Ranibizumab-eqrn Q5149, Enzeevu, Afilbercept-abzv J0178, Eylea, Aflibercept J0177, Eylea HD, Aflibercept Q5153, Opuviz, Aflibercept-yszy Q5155, Yesafili, Aflibercept-jbvf</p> <p>Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued.</p> <p>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:</p> <ol style="list-style-type: none"> 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. 			
Ustekinumab (e.g., Stelara) and Biosimilars	2021028	<p>Preferred/non-preferred products language updated.</p> <p>Select products (e.g., Ustekinumab) 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</p>	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021028

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:

HPCPS, Brand Name, Generic Name

Q9996, Pyzchiva SC, Ustekinumab-ttwe
Q9997, Pyzchiva IV, Ustekinumab-ttwe
Q9998, Selarsdi, Ustekinumab-aekn
Q5100, Yesintek SC, Ustekinumab-kfce
Q5100, Yesintek IV, Ustekinumab- kfce

Non-Preferred Products:

HPCPS, Brand Name, Generic Name

Q5098, Imuldosa SC, Ustekinumab-srlf
Q5098, Imuldosa IV, Ustekinumab-srlf
J3490, Otulfi SC, Ustekinumab-aauz
J3490, Otulfi IV, Ustekinumab-aauz
J3357, Stelara SC, Ustekinumab
J3358, Stelara IV, Ustekinumab
Q5099, Steqeyma SC, Ustekinumab-stba
Q5099, Steqeyma IV, Ustekinumab-stba
Q5137, Wezlana SC, Ustekinumab-auub
Q5138, Wezlana IV, Ustekinumab-auub

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

		<p>unless the form is completed and submitted to the FDA); OR</p> <p>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.</p>			
White Blood Cell Growth Factors (Colony Stimulating Factors)	2021024	<p>Preferred/non-preferred products language updated.</p> <p>Select products (e.g., Zarxio, Nivestym, Fulphila, Neulasta, and Neulasta OnPro) 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.”</p> <p>Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u></p> <p>Q5108, Fulphila, Pegfilgrastim-jmdb J2506, Neulasta, Pegfilgrastim J2506, Neulasta OnPro, Pegfilgrastim Q5110, Nivestym, Filgrastim-aafi Q5101, Zarxio, Filgrastim-sndz</p> <p>Non-Preferred Products:</p> <p><u>HCPCS, Brand Name, Generic Name</u></p> <p>Q5130, Fylnetra, Pegfilgrastim-pbbk J1447, Granix, Tbo-filgrastim J2820, Leukine, Sargramostim J1442, Neupogen, Filgrastim Q5148, Nypozi, Filgrastim-txid Q5122, Nyvepria, Pegfilgrastim-apgf Q5125, Releuko, Filgrastim-ayow</p>	Yes	5/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021024

		<p>J1449, Rolvedon, Eflapegrastim-xnst J9361, Ryzneuta, Efbemalenograstim alfa-vuxw Q5127, Stimufend, Pegfilgrastim-fpgk Q5111, Udenyca, Pegfilgrastim-cbqv Q5111, Udenyca Onbody, Pegfilgrastim-cbqv Q5120, Ziextenzo, Pegfilgrastim-bmez</p> <p>Initial request must be for a preferred product. If initial request is not a preferred product, an administrative denial will be issued.</p> <p>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:</p> <ol style="list-style-type: none">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); OR2. 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.			
--	--	---	--	--	--