PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	**POLICY NUMBER**	**CRITERIA CHANGE**	**MATERIAL AMENDEMENT**	**EFFECTIVE DATE**	**LINK TO FULL POLICY**
Rituximab (e.g., Rituxan) and Biosimilars and Rituximab and Hyaluronidase (e.g., Rituxan Hycela)- Oncologic Indications	2006016	Preferred/non-preferred products updated. **Preferred:** Riabni Truxima **Non-preferred:** Rituxan Rituxan Hycela Ruxience	No	1/1/2026	Coverage Policy Manual - Arkansas Blue Cross and Blue Shield