

PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMEUREMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Intravitreal, Punctum Corticosteroid Implants (e.g., Retisert, Yutiq, Iluvien, Ozurdex, and Dextenza)	2010046	Coverage criteria updated. Coverage added for Iluvien for non-infectious uveitis.	No	1/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2010046
Ranibizumab (e.g., Susvimo)	2025032	Ranibizumab (e.g., Susvimo) was removed from policy Coverage Policy #2010046 and a new policy created. Coverage added for the following indications: • Diabetic macular Edema (DME); • Diabetic Retinopathy (DR).	No	1/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025032
Self-Administered Medication	2020005	Added Olezarsen (e.g., Tryngolza) added to self-administration list. Code updated for Omalizumab-igec (e.g., Omyclo), Q5154.	No	1/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2020005
Testosterone Therapy	2015028	Coverage criteria updated. Continuation of therapy criteria added: CONTINUATION OF THERAPY: 1. Individual continues to meet the initial approval criteria; AND 2. Individual experiences an objective benefit from continued treatment.	No	1/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2015028
Rituximab (e.g., Rituxan) and Biosimilars and Rituximab and Hyaluronidase (e.g., Rituxan Hycela)- Oncologic Indications	2006016	Coverage criteria updated. Continuation of therapy criteria added for off-label indications: CONTINUATION OF THERAPY: 1. Individual has previously met all indication-specific criteria; AND 2. Individual experiences an objective benefit from continued treatment.	No	1/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2006016

Cabotegravir ER (e.g., Apretude)	2022003	Policy will be archived effective January 1, 2026.	No	1/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022003
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