Provider Notification of Policy Criteria Change

➢ Certolizumab pegol (e.g., Cimzia) Policy 2024037

Effective October 15, 2025, Policy #2024037 Certolizumab pegol (e.g., Cimzia) will be updated to include a new FDA approved indication for polyarticular juvenile idiopathic arthritis added along with updating the dosage and administration section. The following is the coverage criteria for Polyarticular Juvenile Idiopathic Arthritis:

INITIAL APPROVAL

1. Individual is age 2 years or older; **AND**
2. Individual weights 10 kg or more; **AND**
3. Individual has a diagnosis of Juvenile Idiopathic Arthritis (JIA) as defined by 5 or more joints with active arthritis at baseline (NCT01550003); **AND**
4. Individual an active disease with documented inadequate response (trial of greater than or equal to 3 months) to scheduled NSAIDs (e.g., indomethacin, naproxen, celecoxib) or synthetic DMARDs (e.g., methotrexate) indicated for pJIA (Ringold, 2019); **OR**
5. Individual has an active disease with intolerance or contraindication to scheduled NSAIDs (e.g., indomethacin, naproxen, celecoxib) or synthetic DMARDs (e.g., methotrexate, sulfasalazine) indicated for pJIA (Ringold, 2019); **OR**
6. Individual has previously received a biologic (e.g., golimumab, abatacept, tocilizumab, certolizumab, adalimumab, sarilumab) or targeted synthetic drug (e.g., tofacitinib, upadacitinib) indicated for pJIA (Ringold, 2019); **OR**
7. Individual has disease involvement of high-risk joints (cervical spine, wrist, or hip), high disease activity, and/or is at high risk of disabling joint damage as assessed by rheumatologist/immunologist (Kimura, 2021); **AND**
8. 7. Individual is not using the medication in combination with other biologic intended for treatment of rheumatoid arthritis, including but not limited to: TNF inhibitor, IL-36 inhibitor, PDE4 inhibitor, any other IL inhibitor, or Janus kinase inhibitor.

CONTINUATION OF THERAPY

1. Individual has met criteria for initial approval; **AND**
2. Individual has experienced a documented positive clinical response; **AND**
3. Individual is not using the medication in combination with any other biologic, including but not limited to: TNF inhibitor, any IL inhibitor, or Janus kinase inhibitor.

The complete policy can be viewed at the following link:
https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024037

➢ Romosozumab-aqqg (e.g., Evenity) Policy 2019009

Effective October 15, 2025, Policy #2019009 Romosozumab-aqqg (e.g., Evenity) will be updated. The policy will be updated to revise the criteria for bone mineral density T-score in the spine, femoral neck, total hip or distal 1/3 of the radius in postmenopausal female with a diagnosis of osteoporosis at very high risk of fracture from -3.0 or less to less than or equal to -2.5.

The complete policy can be viewed at the following link:

https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2019009

➢ Amivantamab-vmjw (e.g., Rybrevant) Policy 2021040

Effective October 15, 2025, Policy 2021040 Amivantamab-vmjw (e.g., Rybrevant) will be revised. The following changes will be made.

Continuation criteria will be added for labeled and off-label indications:

CONTINUATION OF THERAPY

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.

Off-label indications updated.

Added NCCN 2A guidelines for CNS, limited brain mets and extensive brain mets.

INITIAL APPROVAL

1. Central Nervous System Cancers:
    a. Limited Brain Metastases (NCCN 2A):
        i. Used in combination with lazertinib or in combination with carboplatin and pemetrexed for limited brain metastases in non-small cell lung cancer with exon 19 deletion or L858R:
            1. May be considered as initial treatment in select cases for new diagnosed or stable systemic disease or if reasonable systemic treatment options exist; **OR**
            2. Consider as treatment for recurrent brain metastases; **OR**
    b. Extensive Brain Metastases (NCCN 2A):
        i. Used in combination with lazertinib or in combination with carboplatin and pemetrexed for extensive brain metastases in non-small cell lung cancer with exon 19 deletion or L858R:
            1. Mayb be conserved as primary treatment in select cases (e.g., small asymptomatic brain metastases); **OR**
            2. As treatment for recurrent disease with stable systemic disease or reasonable systemic treatment options.

The complete policy can be viewed at the following link:
https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021040

➢ Ipilimumab (e.g., Yervoy) Policy 2011006

Effective October 15, 2025 Policy #2011006, Ipilimumab (Yervoy) will be revised. Changes include:

New FDA approved indication added for the first-line treatment of adult individuals with unresectable advanced or metastatic esophageal squamous cell carcinoma (ESCC) whose tumors express PD-L1 (greater than or equal to 1) combination with nivolumab.

Labeled Indications:
Melanoma: Added as a single agent. Added continuation criteria that individual continues to meet the initial approval criteria; AND Documentation indicating disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread.

Renal Cell Carcinoma: Added the following continuation criteria: Individual continues to meet the initial approval criteria; **AND** Documentation indicating disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread.

Colorectal cancer:

Removed criterion “that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan, in combination with nivolumab”. Added the following continuation criteria: Individual continues to meet the initial approval criteria; **AND** Documentation indicating disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread.

Hepatocellular Carcinoma (HCC):

Added “unresectable or metastatic” to HCC criterion. Added criterion for “Treatment of adult individuals with unresectable or metastatic hepatocellular carcinoma as first-line therapy with combination with nivolumab”. Added the following continuation criteria: Individual continues to meet the initial approval criteria; **AND** Documentation indicating disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread.

Non-Small Cell Lung Cancer(NSCLC) and Malignant Pleural Mesothelioma:

Added the following continuation criteria: Individual continues to meet the initial approval criteria; **AND** Documentation indicating disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread.

Esophageal Cancer:

Changed initial approval criteria for treatment of adult individuals with unresectable advanced metastatic esophageal squamous cell carcinoma as first line treatment in combination with nivolumab to include requirement for tumors expressing PD-L1 (greater than or equal to 1). Added the following continuation criteria: Individual continues to meet the initial approval criteria; **AND** Documentation indicating disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread.

Off-labeled Indications:

Added the following NCCN 2A guidelines: Appendiceal Adenocarcinoma, Dedifferentiated Liposarcoma with or without Concurrent Well-Differentiated Liposarcoma , Epithelioid Hemangioendothelioma, Gestational Trophoblastic Neoplasia, Neuroendocrine and Adrenal Tumors, Central nervous System Cancers: Limited Brain Metastases and Extensive Brain Metastases. Added the following continuation criteria: Individual continues to meet the initial approval criteria; **AND** Documentation indicating disease response to treatment, by stabilization of disease and decrease in size of tumor or tumor spread.

The complete policy can be viewed at the following link:

https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2011006

Notice of Material Amendment

- **Thermal Ablation of Peripheral Nerves and Genicular Artery Embolization to Treat Pain Policy 2016008**

Effective November 15, 2025, Policy #2016008 will be revised to add Genicular artery embolization for the treatment of knee pain as non-covered.

The complete policy can be viewed at the following link:
https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2016008