PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	**POLICY NUMBER**	**CRITERIA CHANGE**	**MATERIAL AMENDEMENT**	**EFFECTIVE DATE**	**LINK TO FULL POLICY**
Growth Hormone, Human	1997087	Effective April 4, 2026, this policy will be archived.	No	04/04/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1997087
Carfilzomib (e.g., Kyprolis)	2021003	Continuation of therapy criteria added for FDA 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.	Yes	05/04/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2021003
RTM_Diagnostic Testing of Iron Homeostasis and Metabolism	2024036	Effective May 1, 2026, coverage criteria will be updated. **Meets Primary Coverage Criteria Or Is Covered For Contracts Without Primary Coverage Criteria** Measurement of serum ferritin levels (no more than one test per month unless otherwise specified) meets member benefit certificate **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts **without Primary Coverage Criteria** is considered **Medically Necessary** and is covered in **any** of the following situations: 1. For individuals with anemia;; 2. Once every three weeks for individuals with iron overload disorders; 3. Individuals with symptoms of hemochromatosis, (See Note 1); 4. Individuals with first-degree relatives (See Note 2) with confirmed hereditary hemochromatosis (HH); 5. Evaluation of individuals with liver disease;	Yes	05/01/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024036

		6. Evaluation of hemophagocytic lymphohistiocytosis (HLof H) and Still Disease; 7. In males with secondary hypogonadism; **8.** For individuals who have chronic kidney disease: **1.** One test every three months if the individual is not receiving dialysis; **OR** 2. One test every month if the individual is receiving dialysis. 9. For individuals on iron therapy. 10. For individuals with restless leg syndrome (RLS) or periodic limb movement disorder. Measurement of serum transferrin saturation meets member benefit certificate **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts **without Primary Coverage Criteria** is considered **Medically Necessary** and is covered in **any** of the following situations: 1. Evaluation of iron overload in individuals with symptoms of hemochromatosis (See Note 1); 2. Evaluation of iron overload in individuals with first-degree relatives (See Note 2) with confirmed hereditary hemochromatosis (HH); 3. Evaluation of iron deficiency anemia. 4. For individuals with restless leg syndrome (RLS) or periodic limb movement disorder. **Note 1:** Symptoms of hemochromatosis (iron overload) (NIDDK, 2020): 1. Fatigue 2. Arrhythmias 3. Joint pain			

		4. Low libido or erectile dysfunction 5. Pain in the knuckles of the index and middle fingers (sometimes called “iron fist”) 6. Skin darkening (a gray or bonze tint) 7. Unexplained weight loss 8. Upper abdominal pain **Note 2**: First-degree relatives include parents, full siblings, and children of the individual. **<u>Does Not Meet Primary Coverage Criteria Or Is Investigational For Contracts Without Primary Coverage Criteria</u>** Measurement of ferritin and transferrin levels, including transferring saturation for any indication or circumstance not described above, including but not limited to the following, does not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes in the following situations: 1. Serum hepcidin testing, including immunoassays; 2. The use of GlycA testing to measure or monitor transferrin or other glycosylated proteins. For members with contracts without Primary Coverage Criteria, measurement of ferritin and transferrin levels, including transferrin saturation for any indication or circumstance not described above, including but not limited to the following, is considered not Medically Necessary or is **investigational. Investigational** services are specific contract exclusions in most member benefit certificates of coverage. 1. Serum hepcidin testing, including immunoassays;			

		2. The use of GlycA testing to measure or monitor transferrin or other glycosylated proteins.			
RTM_Vitamin B12 and Methylmalonic Acid Testing	2024023	Effective May 1, 2026, coverage criteria will be updated. **<u>Meets Primary Coverage Criteria Or Is Covered For Contracts Without Primary Coverage Criteria</u>** A. Total vitamin B12 (serum cobalamin) testing once every three months for any of the following situations meets member benefit certificate **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts **without Primary Coverage Criteria,** is considered **Medically Necessary** and is covered when any following criteria are met: 1. For individuals with the following signs and symptoms of vitamin B12 deficiency: a. Cutaneous i. Hyperpigmentation ii. Jaundice iii. Vitiligo b. Gastrointestinal i. Glossitis c. Hematologic i. Anemia (macrocytic, megaloblastic) ii. Leukopenia iii. Pancytopenia iv. Thrombocytopenia v. Thrombocytosis d. Neuropsychiatric i. Areflexia ii. Cognitive impairment (including dementia-like symptoms and acute psychosis) iii. Gait abnormalities iv. Irritability v. Loss of proprioception and vibratory sense vi. Olfactory impairment	Yes	05/01/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024023

		vii. Peripheral neuropathy 2. For individuals undergoing treatment for vitamin B12 deficiency. 3. For individuals with one or more of the following risk factors: a. For individuals with decreased ileal absorption due to: i. Crohn's disease ii. Ileal resection iii. Tapeworm infection. iv. Having undergone, or for those who have been scheduled for, bariatric procedures such as Roux-en-Y gastric bypass, sleeve gastrectomy, or biliopancreatic diversion/duodenal switch. b. For individuals with decreased intrinsic factor due to: i. Atrophic gastritis ii. Pernicious anemia iii. Postgastrectomy syndrome. c. For individuals with transcobalamin II deficiency d. For individuals with inadequate B12 intake: i. Due to alcohol abuse ii. In individuals older than 75 years or elderly individuals being evaluated for dementia iii. In vegans or strict vegetarians (including exclusively breastfed infants of vegetarian/vegan mothers). iv. Due to an eating disorder. e. For individuals with prolonged medication use: i. Histamine H2 blocker use for more than 12 months ii. Metformin use for more than four months			

		iii. Proton pump inhibitor use for more than 12 months 4. Methylmalonic acid testing may be covered for the following indications: a. To confirm vitamin B12 deficiency in asymptomatic high-risk individuals with low-normal levels of vitamin B12 or when vitamin B12 deficiency is suspected but the serum vitamin B12 level is normal or low-normal; **OR** b. For the evaluation of inborn errors of metabolism. B. In asymptomatic high-risk individuals with low-normal levels of vitamin B12 or when vitamin B12 deficiency is suspected but the serum vitamin B12 level is normal or low-normal, methylmalonic acid testing to confirm vitamin B12 deficiency meets **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts **without Primary Coverage Criteria,** is considered **Medically Necessary** and is covered. C. For the evaluation of inborn errors of metabolism, methylmalonic acid testing meets **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts **without Primary Coverage Criteria,** is considered **Medically Necessary** and is covered. **<u>Does Not Meet Primary Coverage Criteria Or Is Investigational For Contracts Without Primary Coverage Criteria</u>** Screening for vitamin B12 deficiency, for any indication or circumstance not described above, does not meet member benefit certificate **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes including but not limited to screening in			

		asymptomatic healthy individuals and is not covered. For members with contracts without **Primary Coverage Criteria**, screening for vitamin B12 deficiency, for any indication or circumstance not described above, including but not limited to, screening in asymptomatic healthy individuals, is considered not **Medically Necessary** or is **investigational** and is not covered. **Investigational services** are specific contract exclusions in most member benefit certificates of coverage. Homocysteine testing for the confirmation of vitamin B12 deficiency does not meet member benefit certificate **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes and is not covered. For members with contracts without **Primary Coverage Criteria**, homocysteine testing for the confirmation of vitamin B12 deficiency is considered not **Medically Necessary** or is **investigational** and is not covered. **Investigational** services are specific contract exclusions in most member benefit certificates of coverage. Holotranscobalamin testing for screening, testing, or confirmation of vitamin B12 deficiency does not meet member benefit certificate **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes and is not covered. For members with contracts without **Primary Coverage Criteria**, holotranscobalamin testing for screening, testing or confirmation of vitamin B12 deficiency is considered not **Medically Necessary** or is **investigational** and is not covered. **Investigational** services are specific contract exclusions in most member benefit certificates of coverage.			

		Total vitamin B12 (serum cobalamin) testing, for any indication or circumstance not described above, does not meet member benefit certificate **Primary Coverage Criteria** that there be scientific evidence of effectiveness in improving health outcomes and is not covered. For members with contracts without **Primary Coverage Criteria**, total vitamin B12 (serum cobalamin) testing, for any indication or circumstance not described above, is considered not **Medically Necessary** or is **investigational** and is not covered. **Investigational** services are specific contract exclusions in most member benefit certificates of coverage.			