Medical pharmacy

Coverage changes

Arkansas Blue Cross and Blue Shield and its affiliates (BlueAdvantage Administrators of Arkansas and Health Advantage) seek to ensure that health plan members receive **safe and effective medicine** at the **lowest possible cost**.

We have expanded our adoption of **preferred products** to include new therapeutic categories in 2026.

Arkansas Blue Cross and Blue Shield and its affiliates will prefer two to three products in the selected categories across all lines of business (excluding Medicare Advantage, the Federal Employee Program, Arkansas State University, Arkansas State Employees, Public School Employees, Arkansas State Police and Walmart). Preferred product categories for calendar year 2026 include bevacizumab, filgrastim, infliximab, pegfilgrastim, rituximab, trastuzumab, ocular vascular endothelial growth factor inhibitors and ustekinumab.

(***Note:*** *Regarding* ***bevacizumab****, members with an* ***ophthalmic*** *indication will be allowed to use any bevacizumab product and will not be subject to the preferred products.*)

When prescribing for a medication in one of the selected categories, providers should choose from one of the preferred products in the coverage policy. If a provider chooses a **nonpreferred** product, it **will not be covered**. Exception criteria can be found in the coverage policy.

We have directed any member that may be affected by the change to consult their healthcare provider to discuss these changes and have provided them with available alternatives.

All members currently utilizing a non-preferred product will be required to utilize a preferred product in 2026 unless an exception is granted.

The 2026 preferred products are available on the next page. These are subject to change. Please refer to the corresponding coverage policies for the most up-to-date preferred product listings.

To switch to a preferred product – Submit **Authorization | Organizational Determination Request Form** indicating the chosen biosimilar or reference product – along with the corresponding Healthcare Common Procedure Coding System (HCPCS) code. If approved, we will enter a new authorization. As with all such authorizations, it will cover a defined time period and must be renewed at the end of that term.

Category	Preferred (covered)	Non-preferred (non-covered)
Bevacizumab	▪ Mvasi ▪ Zirabev	▪ Avastin ▪ Alymsys ▪ Jobevne ▪ Vegzelma
Filgrastim	▪ Nivestym ▪ Zarxio	▪ Neupogen ▪ Granix ▪ Nypozi ▪ Releuko ▪ Leukine
Infliximab	▪ Remicade ▪ Unbranded Infliximab ▪ Inflectra ▪ Avsola	▪ Renflexis ▪ Ixifi
Pegfilgrastim	▪ Neulasta ▪ Fulphila	▪ Nyvepria ▪ Udenyca ▪ Ziextenzo ▪ Fylnetra ▪ Stimufend ▪ Rolvedon ▪ Ryzneuta
Rituximab	▪ Riabni ▪ Truxima	▪ Rituxan ▪ Ruxience ▪ Rituxan Hycela
Trastuzumab	▪ Kanjinti ▪ Ogivri ▪ Ontruzant	▪ Herceptin ▪ Herceptin Hylecta ▪ Herzuma ▪ Trazimera
Ocular Vascular Endothelial Growth Factor Inhibitors	▪ Byooviz ▪ Lucentis ▪ Vabysmo ▪ Pavblu	▪ Beovu ▪ Cimerli ▪ Ahzantive ▪ Enzeevu ▪ Eylea ▪ Eylea HD ▪ Opuviz
Ustekinumab	▪ Pyzchiva IV and SC ▪ Selarsdi ▪ Yesintek IV and SC	▪ Imuldosa ▪ Otulfi IV and SC ▪ Stelara IV and SC ▪ Steqeyma IV and SC ▪ Wezlana IV and SC