PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **August 10, 2026**

Subject: **Approved Medical Drug Policies**

Summary: **Approved Medical Drug Policies**

AmeriHealth Caritas Louisiana would like to inform you of three updated medical drug policies that have been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54. The guidelines are effective **September 9, 2026**, and will be located at the following link on our website under Pharmacy Prior Authorization Criteria: https://www.amerihealthcaritasla.com/pdf/pharmacy/acla-non-pdl-prior-auth-criteria.pdf.

1. Anti-CD19 CAR-T Immunotherapies
2. Loargys
3. Somatostatin Analogs and Growth Hormone Receptor Antagonists

Reminder: If your practice is not registered with our website portal, NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions:
Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your Provider Network Management Account Executive.

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You can always find a complete listing of provider alerts on the Newsletters and Updates page of our website. page of our website.

Need to update your provider information? Send full details to network@amerihealthcaritasla.com

Field Name	Field Description
Prior Authorization Group Description	**Anti-CD19 CAR-T Immunotherapies**
Drugs	Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel), Breyanzi (lisocabtagene maraleucel), Aucatzyl (obecabtagene autoleucel)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	**Kymriah, Breyanzi:** Patients with primary central nervous system lymphoma
Required Medical Information	See "Other Criteria"
Age Restrictions	See "Other Criteria"
Prescriber Restrictions	Prescriber must be an oncologist, hematologist or other appropriate specialist
Coverage Duration	If all the criteria are met, the initial request will be approved for a single treatment regimen per lifetime. • Kymriah, Yescarta, Tecartus, Breyanzi :a one-time infusion • Aucatzyl: a split-dose infusion administered on day 1 and day 10 (± 2 days)
Other Criteria	****Drug is being requested through the member's medical benefit**** **Initial authorization:** • Patient must not have received prior anti-CD19 CAR-T therapy. • Patient will be screened for HBV, HCV, and HIV in accordance with clinical guidelines. • Patient does not have an active infection or inflammatory disorder. • Patient has a life expectancy >12 weeks. • Patient will not receive live virus vaccines for at least 6 weeks prior to the start of lymphodepleting chemotherapy and until immune recovery following treatment. • Use is supported by a labeled indication or NCCN guidelines **Leukemia** **B-cell precursor Acute Lymphoblastic Leukemia (ALL):** • If the request is for Kymriah o Patient is 25 years of age or younger o ALL that is refractory or in second or later relapse • If the request is for Tecartus or Aucatzyl o Patient is 18 years of age or older o ALL that is relapsed or refractory **Chronic Lymphocytic Leukemia (CLL):** • If the request is for Breyanzi o Patient is 18 years of age or older

	○ Patient has relapsed/refractory disease defined as failure of two or more lines of therapy, including a Bruton tyrosine kinase (BTK) inhibitor AND a B-cell lymphoma 2 (BCL-2) inhibitor **<u>Non-Hodgkin's Lymphoma (NHL)</u>** **Follicular Lymphoma (FL):** • If the request is for Breyanzi, Kymriah, or Yescarta: ○ Patient is 18 years of age or older ○ Patient has relapsed/refractory disease defined as failure of two or more lines of systemic therapy **Large B-cell Lymphoma (LBCL), Diffuse Large B-cell Lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, follicular lymphoma grade 3B, and DLBCL arising from follicular lymphoma or indolent lymphoma:** • If the request is for Breyanzi, Kymriah, or Yescarta ○ Patient is 18 years of age or older ○ For Breyanzi ONE of the following: ▪ Patient is refractory to first-line chemoimmunotherapy or relapsed within 12 months of first-line chemoimmunotherapy ▪ Patient is refractory to first-line chemoimmunotherapy or relapsed after first-line chemoimmunotherapy and is not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age ▪ Patient has relapsed or refractory disease after two or more lines of systemic therapy ○ For Kymriah: Patient has relapsed/refractory disease defined as failure of two or more lines of systemic therapy ○ For Yescarta ONE of the following: ▪ Patient is refractory to first-line chemoimmunotherapy or relapses within 12 months of first-line chemoimmunotherapy or ▪ Patient has failed two or more lines of systemic therapy **Mantle Cell Lymphoma (MCL):** • Patient is 18 years of age or older • If the request is for Tecartus: ○ Patient has relapsed/refractory disease defined as failure of all the following: ▪ Chemoimmunotherapy such as an anti-CD20 monoclonal antibody (e.g. Rituxan) + any chemotherapeutic agent ▪ Bruton Tyrosine Kinase (BTK) Inhibitor (e.g. Calquence, Imbruvica, Brukinsa)

Revision/Review Date: 4/202**6**	• If the request is for Breynazi:
	  o Patient has relapsed or refractory disease who have received at least 2 prior lines of systemic therapy, including a BTK inhibitor
	
	Small Lymphocytic Lymphoma (SLL):
	• If the request is for Breyanzi
	  o Patient is 18 years of age or older
	  o Patient has received at least 2 prior lines of therapy including, a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor
	
	Marginal Zone Lymphoma (MZL):
	• **If the request is for Breyanzi:**
	  o **Patient is 18 years of age or older**
	  o **Patient has relapsed or refractory disease and have received at least 2 prior lines of systemic therapy**
	
	Re-authorization:
	• Treatment exceeding 1 single treatment regimen per lifetime will not be authorized.
	  o **Kymriah, Yescarta, Tecartus, Breyanzi :a one-time infusion**
	  o **Aucatzyl: a split-dose infusion administered on day 1 and day 10 (± 2 days)**
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

Field Name	Field Description
Prior Authorization Group Description	**Loargys (pegzilarginase-nbln)**
Drugs	Loargys (pegzilarginase-nbln)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist or specialist experienced in Urea Cycle Disorders
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.

Other Criteria
 	
Date: 4/2026
	Drug is being requested through the member's medical benefit
	
	Initial Authorization:
	• Medication is prescribed at an FDA approved dose
	• Documentation of patient weight
	• Diagnosis of Arginase 1 Deficiency (ARG1-D) confirmed by one of the following:
	  o Pathogenic variants in ARG1 (copy of genetic results must be submitted with request)
	  o Elevated plasma arginine (pArg)
	  o Diminished erythrocyte ARG1 activity
	• Provider attestation patient will use the drug in conjunction with a protein restricted diet
	• Documentation of baseline pArg
	Re-Authorization:
	• Documentation of positive clinical response as evidenced by normalization in pArg
	• Documentation of patient weight
	• Medication is prescribed at an FDA approved dose
	If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.

Field Name	Field Description
Prior Authorization Group Description	**Somatostatin Analogs and Growth Hormone Receptor Antagonists**
Drugs	Octreotide (Sandostatin) **O**ctreotide **(Sandostatin)** Lanreotide 120 mg/0.5 mL Lanreotide (Somatuline Depot) 60 mg/0.2 mL, 90 mg/0.3 mL, 120 mg/0.5mL Mycapssa (octreotide) Signifor (pasireotide) Signifor LAR (pasireotide) Somavert (pegvisomant)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA) Drug Package Insert (PPI). ** Non-FDA approved (i.e. off-label) uses; refer to the "Oncology Drugs" policy for off-label oncology uses**
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per FDA approved package insert
Prescriber Restrictions	Prescriber must be a specialist with appropriate expertise in treating the condition in question (such as an endocrinologist, neurologist/neurosurgeon, oncologist, etc.). Consultation with appropriate specialist for the condition in question is also acceptable.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria	****Drug is being requested through the member's medical benefit**** **Initial Authorization** For all FDA approved indications (including FDA-approved oncology related uses) • Medication requested is for an FDA approved indication and dose • If the provider is requesting therapy with more than one somatostatin analog or a somatostatin analog and a growth hormone receptor antagonist, then documentation must be submitted as to why patient is unable to be treated with monotherapy, or a medical reason was provided why monotherapy is not appropriate. For Acromegaly

Revision/Review Date 4/202**6**	• Patient has had an inadequate response to, or medical reason why, surgical treatment cannot be used. • If the patient mild disease (e.g. mild signs and symptoms of growth hormone excess, modest elevations in IGF-1) there is a documented trial of a dopamine agonist (e.g. bromocriptine mesylate, cabergoline) at a therapeutically appropriate dose or a documented medical reason why a dopamine agonist cannot be used • **Additionally for Mycapssa:** o Patient has showed clinical response to and tolerates treatment with octreotide or lanreotide therapy o Clinical justification is provided as to why patient cannot continue use of injectable somatostatin analog therapy • **Additionally for Somavert:** o Patient has had an inadequate response to therapy with a somatostatin analog, or has a documented medical reason why a somatostatin analog cannot be used • **Additionally for Signifor LAR:** o Patient has had an inadequate response to therapy with either lanreotide (Somatuline Depot) or octreotide (Sandostain, Sandostatin LAR), or has a documented medical reason why these somatostatin analogs cannot be used. • **Additionally for Palsonify:** o **Patient has had an inadequate response to therapy with an injectable somatostatin analog, or has a documented medical reason why an injectable somatostatin analog cannot be used** o **Clinical justification is provided as to why patient cannot continue use of injectable somatostatin analog therapy** o **Patient has had an inadequate response to therapy with Mycapssa, or has a documented medical reason why Mycapssa cannot be used** For Cushing's Disease (pasireotide products only) • Patient must have had inadequate response, or medical reason why surgical treatment cannot be used **Reauthorization** • Medication requested is for an FDA approved indication and dose • Documentation has been provided that demonstrates a clinical benefit (e.g. improvement in laboratory values, improvement or stabilization of clinical signs/symptoms, etc.)

	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.