BlueCross BlueShield Arizona
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Health Choice

Policy

Department: Medical Management	**Effective Date: 1/1/2020**
Policy Name: Medicare Part B (Outpatient) Step Therapy Program for drugs/products	**Review Date:** 9/3/2019
Policy Number: JC35.0	
Attachments:	**Approved by:** Medical Necessity Criteria Development and Review Committee; CMO
Medicaid ☐ All ☐ AZ ☐ UT **Medicare** ☒ All **Health Choice Integrated Care** ☐ AZ	

I. PURPOSE/BACKGROUND

Certain classes of medical benefit injectable drugs or other products covered under Medicare Part B will include non-preferred therapies that require prior authorization.

Prior authorization for a non-preferred drug/product will require history of use of a preferred drug/product within the same medical benefit injectable class, among other criteria. If a provider administers a non-preferred drug/product without obtaining prior authorization, Health Choice may deny claims for the non-preferred drug/product. The classes of medical benefit injectables that include non-preferred and preferred drug(s)/product(s) subject to prior authorization are listed in this policy.

This policy supplements Medicare NCDs, LCDs, and manuals for the purpose of determining coverage under Medicare Part B medical benefits. This policy implements a prior authorization requirement for prescriptions or administrations of medical benefit injectables only. A member cannot be required under this policy to change from a current a non-preferred drug/product. For the purposes of this policy, a current drug/product means the member has a paid claim for the drug/product within the past 120 days. For example, a new plan member currently using a particular drug/product will not be required to switch to the preferred drug/product upon enrollment. Similarly, an existing member currently using a particular drug/product will not be required to change drugs/products in the event this policy is updated.

II. POLICY

This policy applies Step Therapy for the following drugs/products listed in the table below effective January 1, 2020. Step Therapy will apply when all of the following are met:

1. The requested drug/product meets the definition of a Medicare outpatient (Part B) drug.
2. The requested drug/product is for a new therapy for a member not actively receiving the requested drug/product.
3. The proposed use of the requested product has been determined to be a medically accepted indication.
4. The proposed dose, frequency, and duration of use will not exceed the safety and efficacy data supporting the medically accepted indication.
5. The previous use of the preferred alternative agent has been determined to be for a medically accepted indication.
6. The previous use of the preferred alternative agent occurred in the past 120 days from the date of request for the requested drug/product.
7. The prescriber attests the use of the preferred alternative drug/product resulted in a minimal clinical response and the clinical response is expected to be superior with the requested non-preferred drug/product.

Non-Preferred Drug/Product	**Preferred Alternative Drug(s)/Product(s)**
Epogen/Procrit (J0885)	Retacrit (Q5106)
Eylea (J0178), Lucentis (J2778), Macugen (J2503)	Avastin intravitreal (J7999)
Neulasta (J2505)	Fulphila (Q5108), Udenyca (Q5111)
Neupogen (J1442)	Zarxio (Q5101), Nivestym (Q5110)

III. Coding/Billing

The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by medical necessity criteria and specific benefit plans or other regulatory conditions. This list of codes may not be all inclusive.

IV. Annual Review History

Review Date	**Description of Changes**	Effective Date
9/3/2019	New policy	1/1/2020

This policy will be reviewed on an annual basis.

V. Reference Information

1. Centers for Medicare & Medicaid Services, Health Plan Management System (HPMS), MA_Step_Therapy_HPMS_Memo_8_7_2018. Available at https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf.
2. Local Coverage Determination (LCD). Centers for Medicare & Medicaid Services. http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx.
3. National Coverage Determination (NCD). Centers for Medicare & Medicaid Services. http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx.
4. Health Care medical policy JC23.0 Intravitreal eye injections (Eylea, Lucentis, Macugen, bevacizumab). Last revised Jan 2019.
5. Health Care medical policy JC33.0 ESA products (Retacrit, Epogen, Procrit, Aranesp). Created July 2019.
6. Health Care medical policy JC12.0 Colony Stimulating Factors policy (Filgrastim, Pegfilgrastim, Sargramostim). Last revised Oct 2018.