LifeWise
Health Plan of Washington

Medical Policy and Coding Updates
August 6, 2020

Special notices

Effective October 2, 2020

Miscellaneous Oncology Drugs, 5.01.540

New drugs added to policy

- Kyprolis® (carfilzomib)
  - Treatment of multiple myeloma
- Velcade® (bortezomib)
  - Treatment of multiple myeloma and mantle cell lymphoma

Pharmacotherapy of Arthropathies, 5.01.550

Site of service review added

- Avsola™ (infliximab-axxq)

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563

Site of service review added

- Avsola™ (infliximab-axxq)

Pharmacologic Treatment of Infertility, 5.01.610

New policy

The following drugs may be considered medically necessary when criteria are met:

- Brand Chorionic Gonadotropin
- Bravelle® (urofollitropin)
- Follistim® AQ (follitropin beta)
- Pregnyl® (chorionic gonadotropin)

Prostate Cancer Targeted Therapies, 5.01.544

New drugs added to policy

- Jevtana® (cabazitaxel)
- Xofigo® (radium Ra 223 dichloride)

Rituximab Non-Oncologic and Miscellaneous Uses, 5.01.556

Site of service review added

- Ruxience™ (rituximab-pvvr)

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Site of Service: Infusion Drugs and Biologic Agents, 11.01.523

New drug added to policy

- Avsola™ (infliximab-axxq)

Effective September 4, 2020

Folate Antimetabolites, 5.01.617

New policy

The following drugs may be considered medically necessary when criteria are met:

- Alimta® (pemetrexed)
  - In combination with Keytruda® (pembrolizumab) and platinum chemotherapy for the initial treatment of metastatic non-squamous non-small cell lung cancer (NSCLC)
  - In combination with cisplatin for the initial treatment of locally advanced or metastatic, non-squamous NSCLC
  - As a single agent for the maintenance treatment of locally advanced or metastatic, non-squamous NSCLC in patients whose disease has not progressed after four cycles of platinum-based first-line chemotherapy
  - As a single agent for the treatment of recurrent, metastatic non-squamous, NSCLC after prior chemotherapy
  - Initial treatment, in combination with cisplatin, of malignant pleural mesothelioma in patients whose disease can't be surgically treated or who are not candidates for curative surgery
- Folotyn® (pralatrexate) for the treatment of relapsed or refractory peripheral T-cell lymphoma (PTCL)

Pharmacologic Treatment of Gout, 5.01.616

New policy

The following drug may be considered medically necessary when criteria are met:

- Krystexxa® (pegloticase)
  - Treatment of chronic gout in patients age 18 and older

Effective August 16, 2020

Updates to **AIM Specialty Health® Clinical Appropriateness Guidelines**

Effective for dates of service on and after August 16, 2020, the following updates by will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Radiology: Chest Imaging**

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Updates by section

Tumor or Neoplasm

- Allowed follow up of nodules less than 6 mm in size seen on incomplete thoracic CT, in alignment with follow up recommendations for nodules of the same size seen on complete thoracic CT
- Added new criteria for which follow up is indicated for mediastinal and hilar lymphadenopathy
- Separated mediastinal/hilar mass from lymphadenopathy, which now has its own entry

Parenchymal Lung Disease – not otherwise specified

Removed as it is covered elsewhere in the document (parenchymal disease in "Occupational lung diseases" and pleural disease in "Other thoracic mass lesions")

Interstitial lung disease (ILD), non-occupational, including idiopathic pulmonary fibrosis (IPF)

- Defined criteria warranting advanced imaging for both diagnosis and management

Occupational lung disease (Adult only)

- Moved parenchymal component of asbestosis into this indication
- Added Berylliosis

Chest Wall and Diaphragmatic Conditions

- Removed screening indication for implant rupture due to lack of evidence indicating that outcomes are improved
- Limited evaluation of clinically suspected rupture to patients with silicone implants

Effective for dates of service on and after August 16, 2020, the following updates by will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Radiology: Oncologic Imaging**

Updates by section

MRI breast

- New indication for BIA-ALCL
- New indication for pathologic nipple discharge
- Further define the population of patients most likely to benefit from preoperative MRI

Breast cancer screening

- Added new high risk genetic mutations appropriate for annual breast MRI screening

Lung cancer screening

- Added asbestos-related lung disease as a risk factor

Effective for dates of service on and after August 16, 2020, the following updates by will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Sleep Disorder Management**

Updates by section

Bi-Level Positive Airway Pressure Devices

- Change in BPAP FiO2 from 45 to 52 mmHg based on strong evidence and aligns with Medicare requirements for use of BPAP

Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing

- Style change for clarity

Effective August 7, 2020

IL-5 Inhibitors, 5.01.559

The following drug has been added and may be considered medically necessary when criteria are met:

- Cinqair® (reslizumab)
  - As an add-on maintenance treatment of severe asthma for patients ages 18 and older

Re-authorization criteria added

- A decrease in requirement for oral steroids
- Exacerbation frequency, ER and urgent care visits, and hospitalizations or a decrease in the frequency and severity of asthma symptoms OR
- An increase in quality of life measures and ability to perform activities of daily living

Medical policies

New medical policies Effective August 1, 2020

Ablation of Peripheral Nerves to Treat Pain, 7.01.154

- This policy replaces Ablation of Peripheral Nerves to Treat Pain, 7.01.565
- All policy statements remain unchanged

Amniotic Membrane and Amniotic Fluid, 7.01.583

- This policy replaces Amniotic Membrane and Amniotic Fluid, 7.01.149
- AmnioFix® has been added to the list of human amniotic membrane products that are considered investigational
- All other policy statements remain unchanged

Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions, 7.01.78

- This policy replaces Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions, 7.01.570
- All policy statements remain unchanged

Bioengineered Skin and Soft Tissue Substitutes, 7.01.582

- This policy replaces Bioengineered Skin and Soft Tissue Substitutes, 7.01.113
- All policy statements remain unchanged

Hyperbaric Oxygen Therapy, 2.01.04

- This policy replaces Hyperbaric Oxygen Therapy, 2.01.505
- All policy statements remain unchanged

Interferential Current Stimulation, 1.01.24

- Interferential current stimulation is considered investigational

Radioembolization for Primary and Metastatic Tumors of the Liver, 8.01.43

- This policy replaces Radioembolization for Primary and Metastatic Tumors of the Liver, 8.01.521
- All policy statements remain unchanged

Revised medical policies Effective August 1, 2020

Durable Medical Equipment Repair/Replacement, 1.01.526

Policy renamed

- From "Durable Medical Equipment Repair/Replacement (Excluding Wheelchairs)" to "Durable Medical Equipment Repair/Replacement"

Medical necessity criteria updated

- Includes wheelchair repairs

Revised pharmacy policies
Effective August 1, 2020

BRAF and MEK Inhibitors, 5.01.589

New drug added to policy

The following drug may be considered medically necessary when criteria are met:

- Koselugo™ (selumetinib)
  - Treatment of pediatric patients 2 years and older with neurofibromatosis type 1 (NF1) who have symptomatic, inoperable plexiform neurofibromas (PN)

Drugs for Rare Diseases, 5.01.576

Drug with new indication

- Crysvita® (burosumab)
  - Treatment of fibroblast growth factor 23 (FGF23)-related hypophosphatemiain in tumor induced osteomalacia (TIO) associated with phosphaturic mesenchymal tumors that cannot be treated by surgery in adults and children age 2 and older

Medical necessity criteria updated

- Tepezza™ (teprotumumab-trbw)
  - Treatment of thyroid eye disease

Herceptin® (trastuzumab) and Other HER2 Inhibitors, 5.01.514

Quantity limits added

- Nerlynx® (neratinib)

Medical necessity criteria updated

- Perjeta® (pertuzumab)

New drug added to policy

- Phesgo™ (pertuzumab, trastuzumab, and hyaluronidase-zzxf)
  - In combination with docetaxel or paclitaxel for previously untreated HER2-positive breast cancer or breast cancer that has returned
  - In combination with chemotherapy as part of early treatment for HER2-positive breast cancer
  - In combination with chemotherapy for HER2-positive breast cancer

Immune Checkpoint Inhibitors, 5.01.591

Drugs with new indications

- Keytruda® (pembrolizumab)

    - As a first-line treatment of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer that is metastatic or is not curable by surgery
    - For adults and children with inoperable or metastatic tumor mutational burden-high (TMB-H) [≥10 mutations/megabase (mut/Mb)] solid tumors that have progressed after prior treatment and who have no other alternative treatment options
    - For cutaneous squamous cell carcinoma (cSCC) that has returned or has spread and is not curable by surgery or radiation
- Opdivo® (nivolumab)
    - For advanced and surgically uncurable, recurrent, or metastatic esophageal squamous cell carcinoma (ESCC) after prior fluoropyrimidine- and platinum-based chemotherapy
- Bavencio® (avelumab)
    - For the maintenance treatment of locally advanced or metastatic urothelial carcinoma (UC) that has not progressed with first-line platinum-containing chemotherapy

Medical Necessity Criteria for Pharmacy Edits, 5.01.605

All drugs listed below may be considered medically necessary when criteria are met.

Allergic Conjunctivitis

New policy section

New drugs added to policy

- Alocril® (nedocromil)
- Alomide® (lodoxamide)
- Bepreve® (bepotastine)
- Lastacaft® (alcaftadine)
- Pataday® (olopatadine)
- Pazeo® (olopatadine)
- Zerviate™ (cetirizine)

Anticonvulsants

Dose limits added

- Epidiolex® (cannabidiol)

New drugs added to policy

- Fintepla® (fenfluramine)
- Vigadrone® (vigabatrin)

Atopic Dermatitis
New policy section
New drug added to policy
- Eucrisa® (crisaborole)

Brand Topical Acne and Rosacea Products
New drug added to policy
- Zilxi™ (minocycline)

Chelating Agents
New drug added to policy
- Clovique™ (trientine)

Brand Oral Antibiotics
New drug added to policy
- Solosec® (secnidazole)

Heart Failure Agents
Drug with new indication
- Entresto® (sacubitril/valsartan)

New drug added to policy
- Farxiga® (dapagliflozin)

Inhaled Corticosteroids
New policy section
New drugs added to policy
- Alvesco® (ciclesonide)
- Asmanex® HFA (mometasone)
- Asmanex® Twisthaler® (mometasone)
- Pulmicort Flexhaler® (budesonide)

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) and Combinations
New drug added to policy
- Sprix® (ketorolac tromethamine)

Rifamycin Antibiotics
Medical necessity criteria updated
- Xifaxan® (rifaximin) for the treatment of adult patients with Small Intestinal Bacterial Overgrowth (SIBO)

Testosterone Replacement Products

Medical necessity criteria updated

- Testosterone gel 2% included as a trial drug

Removed from policy

- Axiron® (testosterone topical solution). This drug is no longer available.

Treatment of Nausea/Vomiting

New policy section

New drugs added to policy

- Bonjesta® (doxylamine and pyridoxine extended-release)
- Diclegis® (doxylamine and pyridoxine delayed-release)

Quantity Limits Table

Drugs that have been removed

- Chloroquine
- Hydroxychloroquine
- Plaquenil® (hydroxychloroquine)
- Lopinavir/ritonavir
- Kaletra® (lopinavir/ritonavir)
- Azithromycin
- Zithromax® (azithromycin)

Medical Benefit Drugs Table

Medical necessity criteria updated

- Testopel®

Pharmacotherapy of Cushing's Disease and Acromegaly, 5.01.548

New drug added to policy

- Isturisa® (osilodrostat)

Pharmacotherapy of Type I and Type II Diabetes Mellitus, 5.01.569

Medical necessity criteria updated

- See "Coverage Criteria" in all Preferred Insulin and Non-preferred Insulin tables

Rapid-Acting Insulin

Drug added to Non-preferred

- Lyumjev™ (lispro)

Long-Acting Insulin

Drugs added to Preferred

- Lantus® (glargine)

- Levemir® (determir)
- Toujeo® (glargine)
- Tresiba® (degludec)

Drug added to Non-preferred

- Basaglar® (glargine)

Dipeptidyl Peptidase IV Inhibitors (DPP-4)

Drug added to Preferred

- Tradjenta® (linagliptin)

Drug removed from Preferred

- Onglyza® (saxagliptin)

Drug added to Non-preferred

- Onglyza® (saxagliptin)

Drug removed from Non-preferred

- Tradjenta® (linagliptin)

DPP-4 and Biguanide Combination

Drugs added to Preferred

- Jentadueto® (linagliptin + metformin)
- Jentadueto® XR (linaglitpin + metformin extended-release)

Drugs removed from Preferred

- Kombiglyze® (saxagliptin + metformin)
- Kombiglyze® XR (saxagliptin + metformin extended release)

Drug added to Non-preferred

- Kombiglyze® XR (saxagliptin + metformin extended release)

Drugs removed from Non-preferred

- Jentadueto® (linagliptin + metformin)
- Jentadueto® XR (linaglitpin + metformin extended-release)

Sodium-Glucose Cotransporter 2 Inhibitors (SGLT-2)

Drugs removed from Preferred

- Invokana® (canagliflozin)
- Steglatro® (ertugliflozin)

Drugs added to Non-preferred

- Invokana® (canagliflozin)
- Steglatro® (ertugliflozin)

SGLT-2 and Biguanide Combination

New drug category added

Drugs added to Preferred

- Synjardy® (empagliflozin + metformin)
- Synjardy® XR (empagliflozin + metformin extended-release)
- Xigduo® XR (dapagliflozin + metformin extended-release)

Drugs added to Non-preferred

- Invokamet® (canagliflozin + metformin)
- Invokamet® XR (canagliflozin + metformin extended-release)
- Segluromet® (ertugliflozin + metformin)

DPP-4 and SGLT-2 Combination

Drug removed from Preferred

- Steglujan™ (ertugliflozin + sitagliptin)

Drugs added to Non-preferred

- Steglujan™ (ertugliflozin + sitagliptin)
- Trijardy™ XR (empagliflozin + linagliptin + metformin)

Archived policies

No updates this month

Deleted policies

Ablation of Peripheral Nerves to Treat Pain, 7.01.565
This policy is replaced with Ablation of Peripheral Nerves to Treat Pain, 7.01.154

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This policy is replaced with Amniotic Membrane and Amniotic Fluid, 7.01.583

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Coding updates

Added codes
Effective August 1, 2020

Cosmetic and Reconstructive Services, 10.01.514
Now reviewed for cosmetic and prior authorization.

36468

InterQual® Criteria: Orthoses, Lower Extremity, Knee-Ankle-Foot (KAFO) and Ankle-Foot (AFO)
Now requires review for medical necessity and prior authorization.

L2005

Removed codes
Effective August 1, 2020

Eyelid Thermal Pulsation for the Treatment of Dry Eye Syndrome, 9.03.29
No longer requires review for investigative.

0507T

Focal Treatments for Prostate Cancer, 8.01.61
No longer requires review for investigative.

0582T

Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate or Dermatologic Tumors, 7.01.92
No longer requires review for investigative and prior authorization.

20983

Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate or Dermatologic Tumors, 7.01.92
No longer requires review for investigative.

0581T

Hyperbaric Oxygen Therapy, 2.01.505
No longer requires review for investigative and prior authorization.

A4575

InterQual® Criteria: Services Reviewed for Medical Necessity, 10.01.530
No longer requires review.

27438, 27442, 62662, 62664, 63661, 63688, 64624, 93292, 93745, 0441T, E0270, E0984, E0985, E0988, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1011, E1280

Islet Transplantation, 7.03.12
No longer requires review for medical necessity and prior authorization.

0584T, 0585T, 0586T