LifeWise
Health Plan of Washington

Medical Policy and Coding Updates
April 1, 2021

Special notices

Effective May 10, 2021

Updates to AIM Specialty Health® Clinical Appropriateness Guidelines

Effective for dates of service on and after May 10, 2021, the following updates will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Molecular Testing of Solid and Hematologic Tumors and Malignancies**

Updates by section

Conditions for which testing may be medically necessary (Table 1)
The following solid tumor markers were added:

- Cholangiocarcinoma: FGFR2 and FoundationOne® CDx
- Colorectal cancer: Praxis Extended RAS panel
- Neuroblastoma: Chromosomal Microarray Analysis (CMA), MYCN, ALK
- Non-small cell lung cancer (NSCLC): Oncomine Dx Target Test
- Ovarian cancer: myChoice® CDx
- Prostate cancer (Suspected): SelectMDx
- Prostate cancer: FoundationOne® CDx
- Tumor agnostic/all solid tumors: microsatellite instability (MSI) and FoundationOne® CDx

Breast Cancer Gene Expression Classifiers

- Criteria was clarified to confirm the patient has undergone surgery and full pathological staging
- A statement explaining testing is not medically necessary to guide decision making for extended endocrine therapy was added
- OncotypeDx Recurrence Score test: the definition of unfavorable histological features was clarified

Minimal Residual Disease (MRD)

- Testing criteria was revised to require testing performed on bone marrow

Targeted Molecular Testing for NTRK Fusions
- Criteria were revised

Prostate Cancer (symptomatic cancer screening)
- Added criteria for SelectMDx (81479)
- Criteria for PCA3 (81313), ExomeDx (0005U) and ConfirmMDx (81551) were revised

Effective May 6, 2021

Hereditary Angioedema, 5.01.587
Medical necessity criteria updated
- Berinert® (pdC1-INH)
  - Added coverage for acquired angioedema
- Cinryze® (pdC1-INH)
  - Added patient age, limits to danazol use, and acute HAE frequency requirements
- Firazyr® (icatibant)
  - Requires use of generic icatibant first
- Haegarda® (pdC1-INH)
  - Added limits to danazol use and acute HAE frequency requirements
- Ruconest® (rhC1-INH)
  - Age criteria revised to patients 13 and older
- Takhzyro ® (lanadelumab-flyo)
  - Added limits to danazol use, acute HAE frequency requirements, and quantity limit

Effective April 7, 2021

Immune Globulin Therapy, 8.01.503
Site of service review added
- Xembify®

Miscellaneous Oncology Drugs, 5.01.540
New drug added to policy
- Jelmyto™ (mitomycin)
  - Treatment of adult patients with low-grade upper tract urothelial cancer (LG-UTUC)

Site of Service Infusion Drugs and Biologic Agents, 11.01.523
Site of service review added
- Xembify®

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Medical policies

New medical policies Effective April 1, 2021

Bioengineered Skin and Soft Tissue Substitutes, 7.01.113

New policy

- This policy replaces Bioengineered Skin and Soft Tissue Substitutes, 7.01.582
- The table of investigational products has been updated and expanded
- All statements remain unchanged

Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias, 8.01.538

New policy

- This policy replaces Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias, 8.01.22
- All statements remain unchanged

Pharmacy policies

New pharmacy policies Effective April 1, 2021

Topical Drugs of Actinic Keratosis and Other Dermatologic Conditions, 5.01.623

New policy

The following brand drugs have been added and may be considered medically necessary when criteria are met:

- Aldara® (imiquimod 5%)
  - Treatment of actinic keratosis in adults
  - Treatment of superficial basal cell carcinoma (sBCC) in adults
  - Treatment of external genital and perianal warts (EGW) in patients age 12 and older
- Carac® (fluorouracil 0.5%)
  - Treatment of actinic keratosis in adults
- Fluoroplex® (fluorouracil 1%)
  - Treatment of actinic keratosis in adults
- Brand fluorouracil
  - Treatment of actinic keratosis in adults
- Brand imiquimod 3.75%

        - Treatment of actinic keratosis in adults age 18 and older
        - Treatment of external genital and perianal warts (EGW) in patients age 12 and older
    - Klisyri® (tirbanibulin)
        - Treatment of actinic keratosis in adults
    - Solaraze® (diclofenac 3%)
        - Treatment of actinic keratosis in adults
    - Tolak® (fluorouracil 4%)
        - Treatment of actinic keratosis in adults
    - Zyclara® (imiquimod 2.5% and 3.75%)
        - Treatment of actinic keratosis in adults age 18 and older
    - Zyclara® (imiquimod 3.75%)
        - Treatment of external genital and perianal warts (EGW) in patients age 12 and older

Revised pharmacy policies Effective April 1, 2021

Pharmacotherapy of Arthropathies, 5.01.550

Medical necessity criteria updated

- Cosentyx® (secukinumab)
    - For the treatment of plaque psoriasis, the patient must have tried and failed four drugs from three or more different drug classes
- Cosentyx® (secukinumab)
    - For the treatment of psoriatic arthritis, the patient must have tried and failed three drugs from two or more different drug classes

Removed from site of service review

- Simponi® (golimumab)

Archived policies

An archived policy is one that's no longer active and is not used for reviews.

Effective April 1, 2021

Acute Inpatient Hospice, 11.01.507

Quantitative Assay for Measurement of HER2 Total Protein Expression and HER2 Dimers, 2.04.76

Deleted policies

Effective April 1, 2021

Bioengineered Skin and Soft Tissue Substitutes, 7.01.582
This policy is replaced with **Bioengineered Skin and Soft Tissue Substitutes, 7.01.113**

Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias, 8.01.22
This policy is replaced with **Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias, 8.01.538**

Coding updates

Added codes
Effective April 11, 2021

Effective for dates of service on and after April 11, 2021, the following will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Genetic Testing.**

Now reviewed by AIM® Specialty Health and requires prior authorization.

0242U, 0244U, 0245U

Effective April 7, 2021

Miscellaneous Oncology Drugs, 5.01.540
Now requires review for medical necessity and prior authorization.

J9280

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Effective April 1, 2021

Bioengineered Skin and Soft Tissue Substitutes, 7.01.113
Now requires review for investigative.

Q4108

Chimeric Antigen Receptor Therapy for Hematologic Malignancies, 8.01.63
Now requires review for medical necessity.

Q2053

Drugs for Rare Diseases, 5.01.576
Now requires review for medical necessity.

C9074

Hospital Beds and Accessories, 1.01.520
Now requires review for medical necessity and prior authorization.

E0270

Hyperbaric Oxygen Therapy, 2.01.04
Now requires review for investigative and prior authorization.

A4575

Immune Globulin Therapy, 8.01.503
Now requires review for medical necessity.

J1554

Microprocessor-Controlled and Powered Prostheses and Orthoses for the Lower Limb, 1.04.503
Now requires review for medical necessity and prior authorization.

K1014

Miscellaneous Oncology Drugs, 5.01.540
Now requires review for medical necessity and prior authorization.

J9280

Miscellaneous Oncology Drugs, 5.01.540
Now requires review for medical necessity.

J9037

Monoclonal Antibodies for the Treatment of Lymphoma, 2.03.502
Now requires review for medical necessity and prior authorization.

J9349

Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone Marrow), 8.01.52
Now requires review for investigative.

0565T, 0566T

Pharmacologic Treatment of Duchenne Muscular Dystrophy, 5.01.570
Now requires review for medical necessity.

J1427

Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions, 2.01.16
Now requires review for investigative.

S9055, G0460

Steroid-Eluting Sinus Stents, 7.01.134
Now requires review for investigative.

S1091

Vagus Nerve Stimulation, 7.01.20
Now requires review for investigative.

K1020

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Removed codes
Effective April 1, 2021

Blepharoplasty, Blepharoptosis and Brow Ptosis Surgery, 7.01.508
No longer requires review for medical necessity and prior authorization.

67909

Chimeric Antigen Receptor Therapy for Hematologic Malignancies, 8.01.63
No longer requires review for medical necessity.

C9073

Immune Globulin Therapy, 8.01.503
No longer requires review for medical necessity.

C9072

Intra-Articular Hyaluronan Injections for Osteoarthritis, 2.01.31
No longer requires review for medical necessity.

J3333

Miscellaneous Oncology Drugs, 5.01.540
No longer requires review for medical necessity.

C9069

Monoclonal Antibodies for the Treatment of Lymphoma, 2.03.502
No longer requires review for medical necessity.

C9070

Pharmacologic Treatment of Duchenne Muscular Dystrophy, 5.01.570
No longer requires review for medical necessity.

C9071

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Steroid-Eluting Sinus Stents, 7.01.134
Now requires review for investigative.

J7401