PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **October 30, 2020**

Subject: **Diabetic Testing Supplies, Remdesivir PA Criteria, and Oncology Drugs PA Criteria Policies**

Summary: Diabetic Testing Supplies, Remdesivir PA Criteria, and Oncology Drugs PA Criteria policies approved by Louisiana Department of Health

AmeriHealth Caritas Louisiana would like to make you aware of the attached policies that have been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54 and **will become effective November 30, 2020**.

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.

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

Where can I find more information on COVID-19?
AmeriHealth Caritas Louisiana has updated its website to streamline communications and important notifications about COVID-19. Please visit http://amerihealthcaritasla.com/covid-19 for update-to-date information for both providers and members, including frequently asked questions, cancellations and postponements, and important provider alerts from AmeriHealth Caritas Louisiana and the Louisiana Department of Health.

Field Name	Field Description
Prior Authorization Group Description	Diabetic Testing Supplies
Drugs	Diabetic Testing Supplies (e.g. glucometers, test strips, lancets, syringes, pen needles)
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	N/A
Prescriber Restrictions	N/A
Coverage Duration	If the criterion is met, the request will be approved for up to a 12 month duration (depending on the diagnosis and usual treatment duration). If criterion is not met, the request will be referred to a clinician for medical necessity review.
Other Criteria	Initial Authorization: Criteria for approval of Non-Preferred products: • Member is legally blind or has reduced visual acuity so that they are unable to see the numbers on ALL of the preferred products and the requested product has a feature that enables the patient to use the meter that is not available on any of the preferred meters. The member (not a caregiver) must be the one using the monitor/strips OR • Member is currently using an insulin pump that needs specific meter compatibility to accurately dose insulin OR • Preferred meter is not compatible with insulin pump recipient is using OR • Member is unable to change to a preferred meter and strip combination due to a cognitive or developmental disability OR • Changing to a preferred meter and strip combination would create undue hardship for the member Criteria for approval over the Quantity Limit for Test Strips: • The member has been stabilized on the current regimen. Stabilization on the current regimen is defined as having the prescription filled at least two times in the past 90 days AND the plan has paid for the previous two fills in excess of the quantity limit. OR • The member has a diagnosis of type 1 diabetes AND

Revision/Review Date 7/2020	• **The member needs to test more than three times per day due to one of the following:**
	  o **The member has not been prescribed test strips previously OR**
	  o **The member's diabetes medication regimen (including insulin) is undergoing changes AND**
	• **Approved quantity will not exceed 200 strips per 30 days**
	OR
	• **The member has a diagnosis of type 2 diabetes AND**
	• **The member needs to test more than once per day due to one of the following:**
	  o **The member has not been prescribed test strips previously OR**
	  o **The member's diabetes medication regimen (including insulin) is undergoing changes AND**
	• **Approved quantity will not exceed 100 strips per 30 days**
	OR
	• **The member has a diagnosis of gestational diabetes AND approved quantity will not exceed 300 strips per day**
	
	Quantity limit overrides are not available for glucose monitors
	
	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	Remdesivir
Drugs	Remdesivir
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), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all of the conditions are met, the request will be approved for a duration consistent with the fact sheet for health care providers associated with the emergency use authorization.
Other Criteria Revision/Review Date 7/2020	Use is consistent with the terms and conditions of the emergency use authorization granted by the US Food and Drug Administration. FDA Emergency Use Authorization Letter: https://www.gilead.com/-/media/files/pdfs/remdesivir/eua-fda-authorization-letter_01may2020.pdf?la=en&hash=1333AAA128ECE91DDBB9BC4F9467C843 Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.

References

1. Remdesivir. Gilead website. Available at https://www.gilead.com/remdesivir. Accessed July 21, 2020
2. FDA emergency use authorization letter. Available at https://www.gilead.com/-/media/files/pdfs/remdesivir/eua-fda-authorization-letter_01may2020.pdf?la=en&hash=1333AAA128ECE91DDBB9BC4F9467C843. Accessed July 21, 2020

Pharmacy Policy Title: Oncology Drugs
Recent review date: 7/2020
New review date: 7/2021

Field Name	Field Description
Prior Authorization Group	**Oncology Drugs**
Drugs	~~Oral and~~ Injectable Oncology Medications (specialty or non-specialty) without medication specific criteria when requested for an oncology diagnosis
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) , and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber is an oncologist, or specialist in type of cancer being treated
Coverage Duration	If the criteria are met, the request will be approved for up to 6 month duration; if the criteria are not met, the request will be referred to a clinical reviewer for medical necessity review.
Other Criteria	**All of the following criteria must be met:** • **The drug is requested through the medical benefit** • ~~The drug is being r~~ **Requested use must be a labeled** ~~for an~~ indication **or be** ~~that is~~ supported by NCCN Category 1 or 2A level of evidence. If the request is for **an off-label use supported by NCCN** as Category 2B recommendation then medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g. allergic reaction, contraindication); **if such a treatment regimen exists**; **AND** • Documentation has been provided of the results of all required genetic testing where required per drug package insert; **AND** • Documentation has been provided of the results of all required laboratory values and patient specific information (e.g. weight, ALT/AST, ~~Creatinine Kinase~~ **creatine kinase**, etc.) necessary to ensure the patient has no contraindications to therapy per drug package insert; **AND** • The medication is being prescribed at a dose that is within FDA

Revision/Review ~~5/2020~~ **7/2020**	approved/NCCN guidelines. • **If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available** o **The provider has either verbally or in writing submitted a member specific reason why the brand name biologic is required based on the member's condition or treatment history.** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**