Medicare Advantage

Policy and Procedure

Subject:	Medical Necessity Review for Part B-Covered Medications
Policy Number:	102
Department:	5B Medicare Advantage
Provision Effective Date:	
Revision Date:	

PURPOSE

Medicare Part B covers a group of medications designed to be given by and billed by a physician (in contrast to medications prescribed for a patient, dispensed by a pharmacy and administered at home (either by the patient him or herself or by a caregiver). Attached to this policy as Appendix A is a comprehensive list of medications covered under Medicare Part B. This policy is developed with the understanding that: 1) federal and state laws may dictate coverage for certain Part B-covered medications, 2) a BlueCross Medicare policyholder's specific plan benefits may specify which Part B-covered medications are covered or considered "preferred" for an individual member, and 3) medical coverage policies will apply to the majority of members, but the clinical details of a member's specific medical needs may need to be considered and reviewed to make a final determination of coverage.

POLICY

Coverage determinations for Part B-covered medications will be reviewed individually beginning with Centers for Medicare & Medicaid Services (CMS)/Medicare coverage criteria (in national or local coverage determinations). Each request will be reviewed using nationally accepted clinical care guidelines (including but not limited to MCG care guidelines, specialty society guidelines and peer-reviewed medical literature). To be approved, any request for a medication must meet the guidelines for "Reasonable and Necessary" contained in the Medicare Program Integrity Manual (100-08) Chapter 13, Section 13.5.4. Specifically, a requested medication must be:

1. Safe and effective.
2. Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after Sept. 19, 2000, which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
3. Appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it meets all the following criteria:

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- Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member
- Furnished in a setting appropriate to the patient's medical needs and condition
- Ordered and furnished by qualified personnel
- One that meets but does not exceed the patient's medical need
- At least as beneficial as an existing and available medically appropriate alternative

SCOPE

Policyholders requiring Part B medications, providers furnishing Part B medications

REFERENCE DOCUMENTS

N/A

DEFINITIONS

Preferred may be defined by both/either most efficacious and safe based on peer-reviewed medical research and/or cost-effective for a patient's condition based on plan coverage.

RESPONSIBILITIES

Medical director, utilization management

PROCEDURE

Authorization as required per medical necessity

Appendix A

Iron sucrose injection
Denosumab injection
Aflibercept injection
Ranibizumab injection
Bevacizumab injection
Injection, onabotulinumtoxina
Euflexxa inj per dose

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Hyalgan or supartz inj dose
Inj ferric carboxymaltos 1 mg
Inj morphine pf epid ithc
Zoledronic acid 1 mg
Epoetin alfa, non-esrd
Orthovisc inj per dose
Inj rituximab, 10 mg
Inj retacrit non-esrd use
Ferumoxytol, non-esrd
Ziconotide injection
Gamunex-c/gammaked
Gammagard liquid injection
Synvisc or synvisc-one
Darbepoetin alfa, non-esrd
Golimumab for iv use 1 mg
Inj ivig privigen 500 mg
Infliximab not biosimil 10 mg
Octagam injection
Inj benralizumab, 1 mg
Inj mogamulizumab-kpkc, 1 mg
Inj truxima 10 mg
Na ferric gluconate complex
Injection, ocrelizumab, 1 mg
Omalizumab injection
Natalizumab injection
Certolizumab pegol inj 1 mg
Inj iron dextran
Injection, mepolizumab, 1 mg
Eculizumab injection
Abatacept injection
Monovisc inj per dose
Arformoterol non-comp unit
Dexamethasone intra implant

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APPROVAL SIGNATURES

Title	Printed Name	Signature	Date

REVISION HISTORY

Implementation Date	Description	Business Owner (Signature Required)	Approval Committee

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