Effective: December 4, 2023

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Public Plans Products

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0939

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Tufts Health Together–MassHealth MCO Plan and Accountable Care Partnership Plans, in conjunction with the other Medicaid managed care organizations (MCOs) in the Commonwealth, follow MassHealth's Unified Formulary for pharmacy benefit coverage of medications and for medical benefit coverage of select medications.

Medications included in this policy require prior authorization on the medical benefit with coverage criteria that mirrors the MassHealth Unified Formulary.

Clinical Guideline Coverage Criteria

The Plan may authorize coverage of a medication listed in the table below for Members when all of the MassHealth Drug List coverage criteria is met (https://mhdl.pharmacy.services.conduent.com/MHDL/).

Drug	HCPCS Code
Abecma	Q2055
Abilify Maintena	J0401
Actemra	J3262
Acthar	J0801
Adakveo	J0791
Aduhelm	J0172
Adstriladrin	J9999
Amondys 45	J1426
Amvuttra	J0225
Aranesp	J0881
Aristada	J1944
Aristada Initio	J1943
Asceniv	J1554
Aveed	J3145
Avsola	Q5121
Benlysta	J0490
Berinert	J0597
Bivigam	J1556
Boniva	J1740
Botox	J0585
Breyanzi	Q2054

Drug	HCPCS Code
Briumvi	J2329
Brixadi	C9154
Camcevi	J1952
Carvykti	Q2056
Cinqair	J2786
Cinryze	J0598
Cortrophin	J0802
Crysvita	J0584
Cutaquig	J1551
Cuvitru	J1555
Dysport	J0586
Eligard	J9217
Empaveli	C9151
Enjaymo	J1302
Entyvio	J3380
Epogen	J0885
epoprostenol	J1325
Evenity	J3111
Exondys51	J1428
Fabrazyme	J0180
Fasenra	J0517
Fensolvi	J1951
Firmagon	J9155
Flebogamma	J1572
Furoscix	J1941
Gamastan	J1460
Gammagard	J1569
Gammagard S/D	J1566
Gammaked	J1561
Gammaplex	J1557
Gamunex	J1561
Geodon	J3486
Givlaari	J0223
Granix	J1447
Hizentra	J1559
HyQvia	J1575
Ilaris	J0638
Ilumya	J3245
Inflectra	Q5103
Infliximab	J1745
Invega Hafye	J2427
Invega Sustenna	J2426
Invega Trinza	J2427
Ixifi	Q5109
Kalbitor	J1290
Krystexxa	J2507

Drug	HCPCS Code
Kymriah	Q2042
Lamzede	J3950
Lemtrada	J0202
Leqvio	J1306
Lunsumio	J9999
Lupaeta pack	J3590
Lupron 7.5	J9217
Lupron 3.75	J1950
Lupron Depot	J1950
Luxturna	J3398
Myobloc	J0587
Nexviazyme	J0219
Nivestym	Q5110
Nplate	J2796
Nucala	J2182
Ocrevus	J2350
Octagam	J1568
Onpattro	J0222
Orencia	J0129
Oxlumo	J0224
Panzyga	J1576
Prevymis	J3490
Privigen	J1459
Probuphine	J0570
Procrit	J0885
Proleukin	J9015
Prolia	J0897
Quzyttir	J3490
Radicava	J1301
Reblozyl	J0896
Rebyota	J1440
Releuko	Q5125
Remicade	J1745
Remodulin	J3285
Renflexis	Q5104
Retacrit	Q5106
Risperdal Consta	J2794
Roctavian	J3590
Ruconest	J0596
Saphenlo	J0491
Signifor LAR	J2502
Simponi Aria	J1602
Sinuva	J7402
Skysona	J3590
Soliris	J1300
Somavert	J9307

Drug	HCPCS Code
Spevigo	J1747
Spinraza	J2326
Spravato	S0013
Stelara	J3358
Sunlenca	J1961
Supprelin LA	J9226
Syfovre	J2781
Synagis	90378
Tecartus	Q2053
Tecvayli	J9380
Testopel	J3490
Tezspire	J2356
Trelstar	J3315
Triptodur	J3316
Trogarzo	J3590
Tzeild	J9381
Ultomiris	J1303
Uplizna	J1823
Vantas	J9225
Veletri	J1325
Viltepso	J1427
Vyepti	J3032
Vyondys 53	J1429
Vyvgart	J9332
Xembify	J1558
Xenpozyme	J0218
Xeomin	J0588
Xgeva	J0897
Xiaflex	J0775
Xolair	J2357
Yescarta	Q2041
Zarxio	Q5101
Zinplava	J0565
Zoladex	J9202
Zolgensma	J3399
Zulresso	J1632
Zynteglo	J3590
Zyprexa Relprevv	J2358

Limitations

- None

Codes

The following code(s) require prior authorization:
See table in Clinical Guideline Coverage Criteria section

Approval And Revision History

March 14, 2023: Reviewed by Pharmacy and Therapeutics Committee

Subsequent endorsement date(s) and changes made:

- March 15, 2023: Reviewed by Medical Policy Approval Committee
- May 2023: Rebyota, Tecvayli, Tzeild, Xenpozyme, and Zynteglo were added to the unified formulary list and Makena and hydroxyprogesterone caproate injection were removed effective June 5, 2023
- July 1, 2023: Administrative update: J2427 was added for Invega Hafyera replacing J3490, J2427 was added for Invega Trinza replacing J2426, C9151 was added for Empaveli replacing J3490, J1576 was added for Panzyga replacing J1599, J9380 was added for Tecvayli replacing C9148, J9381 was added for Tzeild replacing C9149
- July 11, 2023: Changed the name of the Medical Necessity Guideline to Unified Medical Policies. Added Briumvi, Crysvita, Furoscix, Lamzede, Lunsumio, and Sunlenca to the Medical Necessity Guideline. Removed Apretude and Perseris from the Medical Necessity Guideline (effective July 31, 2023).
- September 12, 2023: Added Syfovre to the Medical Necessity Guideline. Updated HCPCS codes for Acthar and Cortrophin (effective October 1, 2023).
- November 14, 2023: Administrative update to update HCPCS code for Rebyota to J1440. Added Adstriladrin, Brixadi Roctavian, and Skysona to the Medical Necessity Guideline (effective 12/4/2023).

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.