

## Pharmacy Medical Necessity Guidelines: Epinephrine Auto-Injectors

Effective: February 9, 2021

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
<p>These pharmacy medical necessity guidelines apply to the following:</p> <p><b>Commercial Products</b></p> <input type="checkbox"/> Tufts Health Plan Commercial products – large group plans <input type="checkbox"/> Tufts Health Plan Commercial products – small group and individual plans <input type="checkbox"/> Tufts Health Freedom Plan products – large group plans <input type="checkbox"/> Tufts Health Freedom Plan products – small group plans <ul style="list-style-type: none"> <li>CareLink<sup>SM</sup> – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</li> </ul> <p><b>Tufts Health Public Plans Products</b></p> <input type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product) <input type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan		<p><b>Fax Numbers:</b>  RXUM: 617.673.0988</p>	

**Note:** This guideline does not apply to Medicare Members (includes dual eligible Members).

### OVERVIEW

#### **FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS**

Epinephrine auto-injectors are indicated in the emergency treatment of allergic reactions (Type 1) including anaphylaxis.

### COVERAGE GUIDELINES

The plan may authorize coverage of a non-preferred epinephrine auto-injector for Members when the following criterion is met:

1. The Member has tried and failed, or the provider indicates inappropriateness to all available generic epinephrine auto-injectors

### LIMITATIONS

1. Coverage of epinephrine auto-injectors will be limited to two auto-injectors per prescription.

### CODES

None

### REFERENCES

1. Adrenaclick (epinephrine) [prescribing information]. Horsham, PA; Amedra; October 2014.
2. Auvi-Q (epinephrine) [package insert]. Richmond, VA: Kaleo; September 2019.
3. EpiPen and EpiPen Jr (epinephrine) [package insert]. Morgantown, WV: Mylan Specialty L.P.; December 2020.

### APPROVAL HISTORY

January 13, 2015: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. January 1, 2016: Administrative change to rebranded template.
2. March 8, 2016: Removed Adrenalin<sup>®</sup> from the criteria because it was not included in the epinephrine auto-injector prior authorization program. Extended the approval duration to life of plan.
3. March 14, 2017: Updated criteria to require that provider must indicate clinical inappropriateness to all available generic epinephrine auto-injectors.
4. May 9, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether.
5. April 10, 2018: No changes.
6. April 9, 2019: Administrative changes made to template.
7. March 10, 2020: No changes.
8. February 9, 2021: No changes.

## **BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be 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 the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy 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 Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

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

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