Antineoplastics

Policy: PHARM-007

Origination Date: 05/24/2018

Reviewed/Revised Date: 08/18/2021

Next Review Date: 08/18/2022

Current Effective Date: 09/01/2021

Disclaimer:
1. Policies are subject to change in accordance with Federal and State notice requirements.
2. Policies outline coverage determinations for all members and clients of University of Utah Health Plans. Refer to the “Policy” and “Lines of Business” section for more information.

Purpose

Antineoplastic agents may be covered for the treatment of an appropriate cancer diagnosis.

Policy/Coverage

1. **Prior Authorization Criteria**
    A. Antineoplastics may be considered medically necessary if the following criteria are met:
        i. Request must be made by an oncologist or hematologist.
        ii. The requested therapy is listed as a category 1, 2A, or 2B* option for treatment according to the National Comprehensive Cancer Network (NCCN) Guidelines
        iii. The requested therapy meets medical necessity criteria (See PHARM-056 Prior Authorization and Medical Necessity):
2. **Re-Authorization Criteria**
    A. Updated clinical documentation must be submitted indicating the compliance and response to therapy, including any improvements or stabilization of the disease. Demonstrated clinical improvement in condition is required for continuation.
3. **Dosage**
    A. Dosing must be performed in accordance to the therapy’s approved package insert or NCCN guidelines.
4. **Exclusions/Contraindications**
    A. The member has any contraindications to the requested therapy.
    B. The request is for experimental or investigational use.
    C. Noncompliance to prior medical or pharmacological therapy may result in denial of coverage.

5. **Approval Duration**
    A. Initial Authorization: up to 12 months
    B. Re-Authorization: up to 12 months
6. **Notes**
    A. * NCCN Categories of Evidence and Consensus:
        i. Category 1: Based upon high-level evidence, there is uniform consensus that the intervention is appropriate.
        ii. Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
        iii. Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
        iv. Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.
        v. All recommendations are category 2A unless otherwise noted.

Lines of Business

1. **University of Utah Health Insurance Plans**
    A. Commercial
    B. MHC
2. **University of Utah Health Plans**
    A. Healthy U
    B. Healthy U Integrated

References:

1. National Comprehensive Cancer Network (NCCN) Guidelines

Date	Review, Revisions, Approvals
05/24/2018	Policy created
05/15/2019	Policy reviewed and approved by P&T Committee
05/12/2020	Removed table that listed Antineoplastic Drug Classes
05/20/2020	Policy reviewed and approved by P&T Committee
06/30/2020	Separated out medical & retail policy. Removed: The requested therapy is not more costly than an approved alternative therapy or sequence of therapies that is likely to produce equivalent therapeutic results as to the treatment of the member's disease.
06/30/2020	Policy reviewed and approved by P&T Committee. Policy effective 07.06.2020
12/10/2020	Changed: The requested therapy has a Food and Drug Administration (FDA) approved indication for the diagnosis **OR** is listed as a category 1, 2A, or 2B* option for treatment according to the National Comprehensive Cancer Network (NCCN) Guidelines, to:

	The requested therapy has a Food and Drug Administration (FDA) approved indication for the diagnosis **AND** is listed as a category 1, 2A, or 2B* option for treatment according to the National Comprehensive Cancer Network (NCCN) Guidelines.
01/27/2021	Policy reviewed and approved by P&T Committee. Updated lines of business to match UUHP Policy Committee. Policy effective 02.01.2021
08/05/2021	Removed: requirement for Food and Drug Administration (FDA) approved indication for the diagnosis Added: The requested therapy meets the following medical necessity criteria (See PHARM-056 Prior Authorization and Medical Necessity):
08/18/2021	Policy reviewed and approved by P&T Committee. Policy effective 09.01.2021

Disclaimer:

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The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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