Antineoplastics

Policy: PHARM-CHIP-007

Origination Date: 07/01/2024

Reviewed/Revised Date: 05/27/2025

Next Review Date: 05/27/2026

Current Effective Date: 06/01/2025

Disclaimer:

1. Policies are subject to change in accordance with Federal and State notice requirements.
2. Policies outline coverage determinations for Healthy U CHIP. Refer to the "Policy" and "Lines of Business" section for more information.
3. Services requiring prior-authorization may not be covered, if the prior-authorization is not obtained.
4. This Pharmacy Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

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-CHIP-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 with 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 Plans**
    A. Healthy U CHIP

References:

1. "National Comprehensive Cancer Network ." *NCCN*, https://www.nccn.org/guidelines/category_1. Accessed 27 Mar. 2025.

Date	Review, Revisions, Approvals
07/01/2024	Healthy U CHIP policy created. Separated out from PHARM-HU-007
09/13/2024	Completed annual review of policy.
09/18/2024	Policy reviewed and approved by the P&T Committee. Policy effective 10.01.2024
03/27/2025	Policy Reviewed for Annual Update
05/27/2025	Policy reviewed and approved by the P&T Committee via e-vote. Policy effective 06.01.2025