Antineoplastics- Medical Infused Drugs

Policy: PHARM-M017

Origination Date: 06/30/2020

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. Antineoplastics may be considered medically necessary for treatment of a cancer diagnosis if the following criteria are met:
    A. Request must be made by an oncologist.
    B. The requested therapy is listed as a category 1, 2A, or 2B* option for treatment according to the National Comprehensive Cancer Network (NCCN) Guidelines.
    C. The requested therapy meets medical necessity criteria (See PHARM-056 Prior Authorization and Medical Necessity)
2. **Dosage**
    A. Dosing must be performed in accordance to the therapy's approved package insert or NCCN guidelines.
3. **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.
4. **Approval Duration**
    A. **Initial Authorization:** up to 12 months
    B. **Re-Authorization:** up to 12 months. 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.

5. **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. Medicare Advantage
    B. Commercial
    C. 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 for a medical and retail policy. Policy reviewed and approved by P&T Committee. Policy effective 07.06.20202
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 the requirement for documentation of a Food and Drug Administration (FDA) approved indication Added: The requested therapy meets 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