

# PROVIDER UPDATE

An Update for Highmark Health Options Providers and Clinicians

## Medical and Drug Policy Update Notice for Sept. 1, 2017

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## Adcetris (brentuximab vedotin)

CLINICAL MEDICATION POLICY	
<b>Policy Name:</b>	Adcetris (brentuximab vedotin)
Policy Number:	MP-035-MD-DE
Approved By:	Medical Management Medical Policy; Clinical Pharmacy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	12/13/2016
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical surgical benefits of the Company’s Medicaid products for medically necessary intravenous infusions of Adcetris (brentuximab vedotin). This medical policy has recently been updated.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

### **DISCLAIMER**

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## Herceptin (trastuzumab)

CLINICAL MEDICATION POLICY	
Policy Name:	Herceptin (trastuzumab)
Policy Number:	MP-023-MD-DE
Approved By:	Medical Management Medical Policy; Clinical Pharmacy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	12/16/2016
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical benefits of the Company’s Medicaid products for medically necessary Keytruda (pembrolizumab) administration.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Keytruda (pembrolizumab)

CLINICAL MEDICATION POLICY	
Policy Name:	Keytruda (pembrolizumab)
Policy Number:	MP-014-MD-DE
Approved By:	Medical Management Medical Policy; Clinical Pharmacy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	12/13/2016
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical benefits of the Company's Medicaid products for medically necessary Keytruda (pembrolizumab) administration.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Opdivo (nivolumab)

CLINICAL MEDICAL POLICY	
<b>Policy Name:</b>	Opdivo (nivolumab)
Policy Number:	MP-015-MD-DE
Approved By:	Medical Management Medical Policy; Clinical Pharmacy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	05/18/2017
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical surgical and specialty pharmacy benefits of the Company’s Medicaid products for medically necessary administration of Opdivo (nivolumab).

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person’s unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Portrazza (necitumumab)

<b>CLINICAL MEDICATION POLICY</b>	
<b>Policy Name:</b>	Portrazza (necitumumab)
<b>Policy Number:</b>	MP-021-MD-DE
<b>Approved By:</b>	Medical Management Medical Policy; Clinical Pharmacy
<b>Provider Notice Date:</b>	08/01/2017
<b>Original Effective Date:</b>	09/01/2017
<b>Annual Approval Date:</b>	07/01/2018
<b>Revision Date:</b>	12/19/2016
<b>Products:</b>	Delaware Medicaid
<b>Application:</b>	All participating hospitals and providers
<b>Page Number(s):</b>	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical benefits of the Company's Medicaid products for medically necessary Portrazza (necitumumab) administration.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Yervoy (Ipilimumab)

CLINICAL MEDICATION POLICY	
<b>Policy Name:</b>	Yervoy (Ipilimumab)
Policy Number:	MP-008-MD-DE
Approved By:	Medical Management Medical Policy; Clinical Pharmacy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	12/13/2016
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical surgical and specialty pharmacy benefits of the Company’s Medicaid and Medicare products for medically necessary administration of Yervoy (Ipilimumab).

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Botox (onabotulinumtoxinA) Injections

CLINICAL MEDICATION POLICY	
Policy Name:	Botox (onabotulinumtoxinA) Injections
Policy Number:	MP-024-MD-DE
Approved By:	Medical Management Medical Policy; Clinical Pharmacy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	N/A
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### POLICY SUMMARY

Highmark Health Options provides coverage under the medical benefits of the Company’s Medicaid products for medically necessary intravenous infusions of Botox (onabotulinumtoxinA) injections.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Granulocyte Colony Stimulating Factors (G-CSFs: Neupogen®, Granix®)

<b>CLINICAL MEDICATION POLICY</b>	
<b>Policy Name:</b>	Granulocyte Colony Stimulating Factors (G-CSFs: Neupogen®, Granix®)
<b>Policy Number:</b>	MP-016-MD-DE
<b>Approved By:</b>	Medical Management Medical Policy; Clinical Pharmacy
<b>Provider Notice Date:</b>	08/01/2017
<b>Original Effective Date:</b>	09/01/2017
<b>Annual Approval Date:</b>	07/01/2018
<b>Revision Date:</b>	N/A
<b>Products:</b>	Delaware Medicaid
<b>Application:</b>	All participating hospitals and providers
<b>Page Number(s):</b>	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical surgical benefits of the Company's Medicaid products for medically necessary Granulocyte Colony Stimulating Factor (G-CSF) such as Neupogen, Granix.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Intravenous Immunoglobulin (IVIG) & Subcutaneous Immune Globulin (SCIG) Therapies

CLINICAL MEDICATION POLICY	
<b>Policy Name:</b>	Intravenous Immunoglobulin (IVIG) & Subcutaneous Immune Globulin (SCIG) Therapies
Policy Number:	MP-055-MD-DE
Approved By:	Medical Management Medical Policy; Clinical Pharmacy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	N/A
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage for intravenous immunoglobulin (IVIG) and subcutaneous immune globulin (SCIG) under the medical benefits of the Company’s Medicaid products when medically necessary in the treatment of primary immune-deficiency, idiopathic thrombocytopenic purpura, Kawasaki syndrome, chronic inflammatory demyelinating polyneuritis (CIDP), multifocal motor neuropathy, and B-cell chronic lymphocytic leukemia (CLL).

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

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## Spinraza™ (nusinersen)

CLINICAL MEDICATION POLICY	
Policy Name:	Spinraza™ (nusinersen)
Policy Number:	MP-048-MD-DE
Approved By:	Medical Management Medical Policy; Clinical Pharmacy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	N/A
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical benefits of the Company’s Medicaid products for medically necessary intravenous administration of Spinraza (nusinersen).

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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<b>CLINICAL MEDICAL POLICY</b>	
<b>Policy Name:</b>	Breast Reconstructive Surgery
Policy Number:	MP-052-MD-DE
Approved By:	Medical Management Medical Policy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	N/A
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

## **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical surgical benefits of the Company’s Medicaid products for medically necessary breast reconstructive surgical procedures.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Bronchial Thermoplasty

CLINICAL MEDICAL POLICY	
<b>Policy Name:</b>	Bronchial Thermoplasty
Policy Number:	MP-050-MD-DE
Approved By:	Medical Management Medical Policy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	N/A
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical surgical benefits of the Company's Medicaid products for the bronchial thermoplasty procedure.

\* The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Carpal Tunnel Syndrome

CLINICAL MEDICAL POLICY	
<b>Policy Name:</b>	Carpal Tunnel Syndrome
Policy Number:	MP-053-MD-DE
Approved By:	Medical Management Medical Policy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	N/A
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical surgical benefits of the Company's Medicaid products for medically necessary carpal tunnel surgical procedures to treat carpal tunnel syndrome.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Enteral Feeding In-Line Cartridge (EFIC™)

CLINICAL MEDICAL POLICY	
<b>Policy Name:</b>	Enteral Feeding In-Line Cartridge (EFIC™)
Policy Number:	MP-054-MD-DE
Approved By:	Medical Management Medical Policy
Provider Notice Date:	08/01/2017
Original Effective Date:	09/01/2017
Annual Approval Date:	07/01/2018
Revision Date:	N/A
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

### **POLICY SUMMARY**

Highmark Health Options does not provide coverage under the medical surgical benefits of the Company's Medicaid products for enteral feeding in-line cartridge.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

<https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy>

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## Implantable Cardioverter-Defibrillator/Subcutaneous Implantable Cardioverter-Defibrillator (ICD/SICD)

<b>CLINICAL MEDICAL POLICY</b>	
<b>Policy Name:</b>	Implantable Cardioverter-Defibrillator/Subcutaneous Implantable Cardioverter-Defibrillator (ICD/SICD)
<b>Policy Number:</b>	MP-049-MD-DE
<b>Approved By:</b>	Medical Management Medical Policy
<b>Provider Notice Date:</b>	08/01/2017
<b>Original Effective Date:</b>	09/01/2017
<b>Annual Approval Date:</b>	07/01/2018
<b>Revision Date:</b>	N/A
<b>Products:</b>	Delaware Medicaid
<b>Application:</b>	All participating hospitals and providers
<b>Page Number(s):</b>	1

### **POLICY SUMMARY**

Highmark Health Options provides coverage under the medical surgical benefits of the Company’s Medicaid products for medically necessary Implantable Cardioverter-Defibrillator (ICD) and Subcutaneous Implantable Cardioverter-Defibrillator (S-ICD) procedures.

\*The full version of this medical policy is available on the Highmark Health Options provider website at:

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