Medical Policy

BlueCross BlueShield Kansas
An Independent licensee of the Blue Cross Blue Shield Association

Title: ACA Prevention Copay Waiver Criteria- Individual Marketplace, Commercial

Professional / Institutional
Original Effective Date: October 1, 2017
Latest Review Date: January 5, 2024
Current Effective Date: January 5, 2024

State and Federal mandates and health plan member contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. To verify a member's benefits, contact Blue Cross and Blue Shield of Kansas Customer Service.

The BCBSKS Medical Policies contained herein are for informational purposes and apply only to members who have health insurance through BCBSKS or who are covered by a self-insured group plan administered by BCBSKS. Medical Policy for FEP members is subject to FEP medical policy which may differ from BCBSKS Medical Policy.

The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents of Blue Cross and Blue Shield of Kansas and are solely responsible for diagnosis, treatment and medical advice.

If your patient is covered under a different Blue Cross and Blue Shield plan, please refer to the Medical Policies of that plan.

CLINICAL RATIONALE

The Affordable Care Act (ACA) requires a member-friendly mechanism for waiving the cost share for an alternative recommended product deemed medically necessary by the provider when a health care provider considers the $0 covered product is inappropriate for an individual. Prime Therapeutics offers a standard coverage exception/cost share waiver policy that is applied across all ACA categories.

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf

Breast Cancer Primary Prevention Agent ACA Copay Waiver Criteria

OBJECTIVE

The intent of the ACA Prevention Copay Waiver Criteria is to help ensure the copay waiver, when applicable based on the member's benefit, is applied to the appropriate population as described by the United States Preventative Services Task Force (USPSTF).

CRITERIA FOR APPROVAL

The requested breast cancer primary prevention agent will be approved when ALL of the following are met:

1. The requested breast cancer primary prevention agent is covered under the pharmacy benefit or has been approved through the coverage exception process
   AND
2. The prescriber has provided information stating that the requested breast cancer primary prevention agent is medically necessary
   AND
3. The requested agent is tamoxifen, raloxifene, or aromatase inhibitor (anastrozole, exemestane, letrozole)
   AND
4. The patient is 35 years of age or over
   AND
5. The agent is requested for the primary prevention of breast cancer
   AND
6. ONE of the following:
   a. The plan has not implemented a sex requirement
      OR
   b. The plan has implemented a sex requirement **AND** ONE of the following:
      i. The patient's sex is female
         OR
      ii. The prescriber has provided information that the requested agent is medically
      appropriate for the patient's sex

Length of Approval: 12 months

Human Immunodeficiency Virus (HIV) Infection: Pre-exposure Prophylaxis (PrEP) ACA Prevention Copay Waiver Criteria

OBJECTIVE

The intent of the ACA Prevention Copay Waiver Criteria is to help ensure the copay waiver, when applicable based on the member's benefit, is applied to the appropriate population as described by the United States Preventative Services Task Force (USPSTF).

CRITERIA FOR APPROVAL

The requested HIV infection pre-exposure prophylaxis (PrEP) agent will be approved when ALL of the following are met:

1. The requested PrEP agent is covered under the pharmacy benefit or has been approved through the coverage exception process
   AND
2. The requested agent is being used for PrEP
   AND
3. The prescriber has provided information stating that the requested PrEP agent is medically necessary compared to other available PrEP agents
   AND
4. ONE of the following:
   a. The requested PrEP agent is ONE of the following:
      i. Tenofovir disoproxil fumarate and emtricitabine combination ingredient agent
         OR
      ii. Tenofovir disoproxil fumarate single ingredient agent
         OR
      iii. Tenofovir alafenamide and emtricitabine combination ingredient agent

   OR

   b. The prescriber has provided information stating that a tenofovir disoproxil fumarate and emtricitabine combination ingredient agent, tenofovir disoproxil fumarate single ingredient agent, or tenofovir alafenamide and emtricitabine combination ingredient agent is contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient

   AND
5. The patient is at high risk of HIV infection
   AND
6. The patient has recently tested negative for HIV

Length of Approval: 12 months

Statin ACA Prevention Copay Waiver Criteria

OBJECTIVE

The intent of the ACA Prevention Copay Waiver Criteria is to help ensure the copay waiver, when applicable based on the member's benefit, is applied to the appropriate population as described by the United States Preventative Services Task Force (USPSTF). The USPSTF recommendation requires the calculation of Atherosclerotic Cardiovascular Disease (ASCVD) risk. The calculation requires inputting the patient's sex, age, race, high density lipoprotein (HDL) cholesterol, total cholesterol, blood pressure, whether the patient has diabetes, whether the patient is under treatment for hypertension, and whether the patient is an active smoker.[1]

1. American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator. Available at: https://tools.acc.org/ASCVD-Risk- Estimator/.

CRITERIA FOR APPROVAL

The requested statin will be approved when ALL of the following are met:

1. The requested agent is a generic statin (MSC=Y) unless a generic statin is not available for the requested agent
   AND
2. The requested statin is covered under the pharmacy benefit or has been approved through the coverage exception process
   AND
3. The prescriber has provided information stating that the requested statin is medically necessary
   AND
4. The requested statin is for use in the primary prevention of cardiovascular disease (CVD)
   AND
5. The patient is 40-75 years of age (inclusive)
   AND
6. The patient has at least one of the following risk factors:
   a. Dyslipidemia
   b. Diabetes
   c. Hypertension
   d. Smoking

   AND
7. The patient has a calculated 10-year risk of a cardiovascular event of 10% or greater per the American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator

Length of Approval: 12 months

REVISIONS	
10-01-2017	Policy added to the bcbsks.com web site.
12-13-2022	Policy reviewed and maintained by Prime Therapeutics with no revisions
01-05-2024	Policy reviewed and maintained by Prime Therapeutics with no revisions