Pharmacy Medical Policy
Cox II Inhibitor Drugs

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Policy Number: 002
BCBSA Reference Number: None

Related Policies
Quality Care Dosing guidelines, #621A

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Prior Authorization Information

<table>
<thead>
<tr>
<th>☒ Prior Authorization</th>
<th>Pharmacy Operations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Step Therapy</td>
<td>Tel: 1-800-366-7778</td>
</tr>
<tr>
<td>☒ Quality Care Dosing</td>
<td>Fax: 1-800-583-6289</td>
</tr>
</tbody>
</table>

Pharmacy (Rx) or Medical (MED) benefit coverage

| ☒ Rx | ☐ MED |

Policy applies to Commercial Members:
- Managed Care (HMO and POS), PPO and Indemnity
- MEDEX with Rx plan
- Managed Major Medical with Custom BCBSMA Formulary
- Comprehensive Managed Major Medical with Custom BCBSMA Formulary
- Managed Blue for Seniors with Custom BCBSMA Formulary

To request for coverage: Physicians may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below.

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043

Individual Consideration: Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration
Please refer to the chart below for the formulary status of the medications affected by this policy.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Formulary Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standard</td>
</tr>
<tr>
<td>Celebrex ® (celecoxib)</td>
<td>PA Required</td>
</tr>
<tr>
<td>Celecoxib</td>
<td>PA Required</td>
</tr>
<tr>
<td>Seglentis ™* (celecoxib/tramadol)</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and step criteria below are met.

We may cover Cox II Inhibitor drugs for patients:

1. **Acute Pain**
   I. Treatment failure with two previous traditional non-COX-II prescription NSAIDs or a contraindication to NSAID use.

2. **Arthritis**
   I. The patient is age 60 or older, **OR**
   II. The patient is 2 years or older with a confirmed diagnosis of Juvenile Rheumatoid Arthritis (JRA), **OR**
   III. The patient has one or more of the following risk factors, **OR**
      a. History of gastrointestinal ulcer or bleeding
      b. Thrombocytopenia
      c. Inflammatory Bowel Disease
   IV. Concurrent treatment with oral or injectable corticosteroids, **OR**
   V. Concurrent treatment with anticoagulants such as warfarin, heparin, Lovenox®, Fragmin®, Innohep®, Arixtra® or high-dose aspirin, **OR**
   VI. Treatment with oral or injectable DMARDs such as methotrexate, gold, Enbrel®, Remicade®, Humira™, Kinere®, sulfasalazine, azathioprine, cyclosporine, hydroxychloroquine, Arava®, Cuprimine®, misoprostol, Supartz™, Synvisc® or Hyalgan® in the last 130 days, **OR**
   VII. Current treatment with Antiplatelet therapy drugs such as Plavix®, clopidogrel cilostazol, dipyridamole, Aggrenox®, or Agrylin®, **OR**
   VIII. Current treatment with 5-Aminosalicylates drugs such as mesalamine, olsalazine, 5-mercaptopurine and balsalazide, **OR**
   IX. Treatment failure with two previous traditional non-COX-II prescription NSAIDs in last 130 days.

3. **Polyposis**
   I. Documentation of familial adenomatous polyposis, for pediatric conditions, submit the patient’s clinical information.

4. **Primary Dysmenorrhea**
   I. Treatment failure with two previous traditional non-COX-II prescription NSAIDs or a contraindication to NSAID use.

**Note:** If approved the Prior Authorization/Step therapy will be granted for up to two (2) years.
Other not listed diagnoses
These will be reviewed and may be approved under Individual Consideration in the best interest of the member.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

We do not cover Cox II Inhibitor drugs for patients who are on low dose aspirin therapy, unless therapy is warranted as outlined above.

For patient safety, we do not cover Cox II Inhibitor drugs for patients with any of the following conditions:

- Active peptic ulcer disease or bleeding
- Sulfa allergy (applies to celecoxib)
- Allergy to aspirin or NSAIDs
- Severe kidney or liver dysfunction
- Age less than 18 unless FDA approved for a specific condition.
- Cardiovascular disease
- Congestive heart failure.

Individual Consideration
All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual’s unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/2023</td>
<td>Reformatted Policy.</td>
</tr>
<tr>
<td>4/2023</td>
<td>Updated to remove CAPXIB &amp; Elyxyb as they manufactures have removed marketing of the medications.</td>
</tr>
<tr>
<td>4/2022</td>
<td>Updated to add Seglentis™ to the policy as non-covered.</td>
</tr>
<tr>
<td>2/2022</td>
<td>Updated to add Elyxyb™ as Nonformulary.</td>
</tr>
<tr>
<td>6/2017</td>
<td>Update Address for Pharmacy Operations.</td>
</tr>
<tr>
<td>6/2016</td>
<td>Added Generic to policy, added JRA indication, and adjusted age language to allow for new FDA indications and added CapXib as non-covered.</td>
</tr>
<tr>
<td>2/2014</td>
<td>Updated ExpressPath language and remove Blue Value.</td>
</tr>
<tr>
<td>2/2012</td>
<td>Updated to include employee fax number on Outpatient Retail Pharmacy Prior Authorization Form.</td>
</tr>
<tr>
<td>9/2009</td>
<td>Policy updated to change 180 day look back period to 130 days, add sample language and to remove Medicare Part D criteria from Medical Policy.</td>
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</tbody>
</table>
References


To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below: