MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy

Benign Prostatic Hyperplasia - BPH

Table of Contents

Policy Number: 040

BCBSA Reference Number: None

Related Policies

None

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.

Please refer to the chart below for the formulary status of the medications affected by this policy.

Drug	Formulary Information Standard Formulary Status
STEP 1	
• **dutasteride**	Covered
• **dutasteride/Tamulosin**	
• **finasteride**	
STEP 2	
• **Avodart**™ (dutasteride)	Prior use of Step 1 Required
• **Jalyn**™ (dutasteride/tamulosin)	
• **Proscar**® (finasteride)	

We cover the benign prostatic hyperplasia (BPH) medications listed in the chart above for new starts* in the following stepped approach.[1]

*New start is defined as no previous paid claim for the requested medication within the past 130 days.

Step 1: Step 1 medications will be covered without prior authorization.

Step 2: Step 2 medications may be covered when one of the following criteria is met:

- There must be evidence of a BCBSMA paid claim by the patient of a step 1 drug within the previous 130 days or previous treatment.

OR

- There must be evidence of a BCBSMA paid claim by the patient of a step 2 drug within the previous 130 days or previous treatment.

**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 drugs listed in the above chart unless the above step therapy criteria are met.

- **Prior Authorization Requirements for tadalafil**:

Tadalafil 5 mg or 2.5 mg may be covered when **ALL** of the following criteria are met:

- Diagnosis of BPH,
  AND
- 60-day trial of Alpha-1 Adrenergic Blockers (e.g. DOXAZOSIN, GUANETHIDINE, PRAZOSIN, TERAZOSIN),
  AND
- Prescribed by a board-eligible or board-certified Urologist,
  AND
- 60-day trial of 5-Alpha Reductase Inhibitor (e.g. finasteride or dutasteride) **OR**
  60-day trial of combination product of 5-Alpha Reductase Inhibitors & Alpha-1 Adrenergic Blockers (e.g. JALYN*#, DUTASTEIDE/TAMSULOSIN)

We may cover **Cialis 5 mg** or 2.5 mg with previous use of **tadalafil** and above criteria was met**.**

Note: All other strengths are managed through Medical policy 078 (**Sexual Dysfunction Diagnosis and Therapy)**

*# Non-formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and requires **TWO** formulary drugs to be tried prior to granting a Formulary Exception (FE).

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

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

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

Policy History

Date	Action
7/2022	Clarified Tadalafil requirements.
9/2019	Updated to revise Step Criteria.
5/1/2019	Updated to change criteria for tadalafil & require the use of a combo product which is aligned with guidelines.
6/2017	Updated address for Pharmacy Operations.
6/2016	Updated to add Dutasteride & Dutasteride/Tamulosin to step 1 and to add Cialis 5mg criteria to policy.
1/2014	Updated ExpressPAth language and remove Blue Value.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
9/2011	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
11/2010	Updated to include coverage criteria for new FDA approved medication Jalyn™.
6/2010	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
9/2009	Policy updated to change 180 day look back period to 130 days, update sample language and to remove Medicare Part D criteria from Medical Policy.
1/1/2008	New policy, effective 1/1/2008, describing covered and non-covered indications.

References

1. Avodart® [package insert]. Research Triangle Park, NC: GlaxoSmithKline; 2007.
2. Proscar® [package insert]. Whitehouse Station, NJ: Merck & Co. In.; 2007.
3. Jalyn™ [package insert]. Research Triangle Park, NC: GlaxoSmithKline; 2010.
4. Cialis® [package insert]. Indianapolis, IN: Lilly USA, LLC; 2015.

Endnotes

1. Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 2/13/2007 and 9/11/2007.

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

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf