



MASSACHUSETTS

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

Pharmacy Medical Policy

Injectable Specialty Medication Coverage

Table of Contents

- [Policy: Commercial](#)
- [Policy: Medicare](#)
- [Coding Information](#)
- [Policy History](#)
- [Information Pertaining to All Policies](#)
- [References](#)
- [Endnotes](#)
- [Forms](#)

Policy Number: 071

BCBSA Reference Number: None

Related Policies

- Quality Care Dosing guidelines may apply to the following medications and can be found in Medical Policy [#621A](#)
- Medical Utilization Management (MED UM) Policy [#033](#)

This policy applies to all members, except:

- Medicare Advantage members
- Federal Employee Program members
- Members with Medicare Supplemental Plans

Injectable Specialty Medication Coverage Information (As of January 1, 2020)

The medications included in this policy are covered under the member's pharmacy benefits only when filled through a specialty pharmacy in our network. Exceptions are noted where applicable in the medication list on the following pages. A valid prescription from a licensed health care provider is required to fill these medications.

Some medications may also be subject to other pharmacy management programs, such as Step Therapy, Prior Authorization, or Quality Care Dosing, or have other coverage requirements. For more information about these medications, use our Medication Lookup tool:

- Medication Lookup for Providers: bluecrossma.com/provider
- Medication Lookup for Members: bluecrossma.com/medications

Important: Providers can't buy and bill us for the medications listed in this policy using the member's medical benefits. (There are exceptions for providers in Massachusetts to buy and bill certain medications that are noted on the list.)

Additional Coverage Information

	Medications Self-Administered at Home	Medications Administered in a Doctor's Office	Medications Administered by a Home Infusion Therapy Provider
Ordering the Medication	The prescriber orders the medication through an in-network retail specialty pharmacy.	The prescriber orders the medication through an in-network retail specialty pharmacy for delivery to the prescriber's office or an outpatient clinic for administration.	The prescriber requests prior authorization for this service. They refer the member to a home infusion therapy provider who procures the medication and administers it in the member's home.
Paying for the Medication	The member is responsible for out-of-pocket prescription costs, such as a copay, deductible, or co-insurance.	The member is responsible for any prescription costs (such as a copay, deductible, or co-insurance) and the cost of the office visit (such as a copay, deductible, or co-insurance).	The member is responsible for any applicable cost sharing outlined under the home care benefit (such as a copay, deductible, or co-insurance).

List of Medications Covered Only Under the Pharmacy Benefit¹ Last Updated: January 1, 2020

This isn't a complete list of covered medications, and inclusion on the list doesn't guarantee coverage. Some members, depending on their pharmacy plan, may not be covered for these medications. Providers should check a member's eligibility and benefits.

Medication	Date added to this list	Medication	Date added to this list
Actimmune	Jan. 1, 2011	Carimmune ³	Sept. 1, 2015
Aranesp	Jan. 1, 2011	Cetrotide	Jan. 1, 2011
Arcalyst	Jan. 1, 2011	Chorionic Conadotropin	Jan. 1, 2011
Avonex	Jan. 1, 2011	Cimzia	Jan. 1, 2011
Betaseron	Jan. 1, 2011	Copaxone	Jan. 1, 2011
Bivigam ³	Sept. 1, 2015	Copegus	Jan. 1, 2011
Botox ³	Sept. 1, 2015	Durolane	Mar 5, 2018
Bravelle	Jan. 1, 2011	Dysport ³	Sept. 1, 2015

Medication	Date added to this list	Medication	Date added to this list
Enbrel	Jan. 1, 2011	Octagam ³	Sept. 1, 2015
Enspryng	Sept. 1, 2020	Octreotide (not LAR)	Jan. 1, 2011
Epogen	Jan. 1, 2011	Octreotide (not LAR)	Jan. 1, 2011
Euflexxa ²	Jan. 1, 2011	Omnitrope	Jan. 1, 2011
Extavia	Jan. 1, 2011	Orfadin	Jan. 1, 2011
Flebogamma ³	Sept. 1, 2015	Orthovisc ²	Jan. 1, 2011
Flebogamma Dif ³	Sept. 1, 2015	Ovidrel	Jan. 1, 2011
Follistim AQ	Jan. 1, 2011	Panglobulin ³	Sept. 1, 2015
Forteo	Jan. 1, 2011	Panretin	Jan. 1, 2011
Fuzeon	Jan. 1, 2011	Pegasys	Jan. 1, 2011
Gamastan SD ³	Sept. 1, 2015	PegIntron	Jan. 1, 2011
Gammagard liquid ³	Sept. 1, 2015	PegIntron Redi Pen	Jan. 1, 2011
Gammaplex ³	Sept. 1, 2015	Pregnyl	Jan. 1, 2011
Gamunex ³	Sept. 1, 2015	Privigen ³	Sept. 1, 2015
Gamunex-C ³	Sept. 1, 2015	Procrit	Jan. 1, 2011
Gammaked ³	Sept. 1, 2015	Prolia ³	Sept. 1, 2015
Ganirelix	Jan. 1, 2011	Pulmozyme	Jan. 1, 2011
Gel-One ²	Jan. 1, 2011	Rebetol	Jan. 1, 2011
Gel-Syn ²	Jan. 1, 2011	Rebetron	Jan. 1, 2011
Genotropin	Jan. 1, 2011	Rebif	Jan. 1, 2011
Genvisc	Jan. 1, 2011	Remicade ³	Sept. 1, 2015
Glatiramer	Oct. 3, 2017	Repronex	Jan. 1, 2011
Glatopa	Apr. 16, 2015	RibaPak	Jan. 1, 2011
Gonal F	Jan. 1, 2011	Ribasphere	Jan. 1, 2011
Gonal F RFF	Jan. 1, 2011	Ribavirin	Jan. 1, 2011
Hizentra ³	Sept. 1, 2015	Saizen	Jan. 1, 2011
Humatrope	Jan. 1, 2011	Sandostatin (not LAR)	Jan. 1, 2011
Humira	Jan. 1, 2011	Serostim	Jan. 1, 2011
HyQvia	Sept 12, 2014	Simponi (does not include Simponi Aria)	Jan. 1, 2011
Ilaris	Jan. 1, 2011	Somavert	Jan. 1, 2011
Increlex	Jan. 1, 2011	Stelara (not IV form)	Jan. 1, 2011
Infergen	Jan. 1, 2011	Supartz ²	Jan. 1, 2011
Kesimpta	Sept 1, 2020	Synvisc ² (all forms)	Jan. 1, 2011
Kineret	Jan. 1, 2011	Teriparatide	Mar, 1, 2020
Leuprolide (non-Depot form)	Jan. 1, 2011	Tev-Tropin	Jan. 1, 2011
Luveris	Jan. 1, 2011	TOBI	Jan. 1, 2011
Menopur	Jan. 1, 2011	Tymlos	Jan. 1, 2011
Myobloc ³	Sept. 1, 2015	Visco-3 ²	Jan. 1, 2011
Nordiflex	Jan. 1, 2011	Xeomin ³	Sept. 1, 2015
Norditropin	Jan. 1, 2011	Xgeva ³	Sept. 1, 2015
Nutropin	Jan. 1, 2011	Zorbtive	Jan. 1, 2011
Nutropin AQ	Jan. 1, 2011		

Footnotes

1. Does not apply when the medication is administered: in the emergency room; as an inpatient; at a surgical day care facility; in an ambulatory surgery center; or through home infusion therapy or dialysis.
2. This medication can be filled at any retail pharmacy. The member doesn't need to use a retail specialty pharmacy in our network for these medications only.
3. These medications are covered under the *pharmacy benefit* when filled at an in-network specialty pharmacy. However, they may be covered under the *medical benefit* by a doctor who practices in Massachusetts and administered based on the member's benefits.

Policy History

Date	Action
9/1/2020	Updated to add Kesimpta and Enspryng to the policy.
3/1/2020	Policy developed based on current process.

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>