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

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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 Benefit[1]
Last Updated: January 13, 2022

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	Bynfezia	July 1, 2021
Aranesp	Jan. 1, 2011	Carimune[3]	Sept. 1, 2015
Arcalyst	Jan. 1, 2011	Cetrotide	Jan. 1, 2011
Avonex	Jan. 1, 2011	Chorionic Gonadotropin	Jan. 1, 2011
Betaseron	Jan. 1, 2011	Cimzia	Jan. 1, 2011
Bivigam[3]	Sept. 1, 2015	Copaxone	Jan. 1, 2011
Botox[3]	Sept. 1, 2015	Copegus	Jan. 1, 2011
Bravelle	Jan. 1, 2011	Cosentyx	July 1, 2021

Medication	Date added to this list	Medication	Date added to this list
Dupixent	July 1, 2021	Nordiflex	Jan. 1, 2011
Durolane	Mar 5, 2018	Norditropin	Jan. 1, 2011
Dysport[3]	Sept. 1, 2015	Nucala	July 1, 2021
Enbrel	Jan. 1, 2011	Nutropin	Jan. 1, 2011
Enspryng	Sept. 1,2020	Nutropin AQ	Jan. 1, 2011
Epogen	Jan. 1, 2011	Octagam[3]	Sept. 1, 2015
Euflexxa[2]	Jan. 1, 2011	Octreotide (not LAR)	Jan. 1, 2011
Extavia	Jan. 1, 2011	Omnitrope	Jan. 1, 2011
Fasenra	July 1, 2021	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
GelSyn-3[2]	July 1, 2021	Rebif	Jan. 1, 2011
Genotropin	Jan. 1, 2011	Remicade[3]	Sept. 1, 2015
Genvisc	Jan. 1, 2011	Repronex	Jan. 1, 2011
Glatiramer	Oct. 3,2017	RibaPak	Jan. 1, 2011
Glatopa	Apr. 16,2015	Ribasphere	Jan. 1, 2011
Gonal F	Jan. 1, 2011	Ribavirin	Jan. 1, 2011
Gonal F RFF	Jan. 1, 2011	Saizen	Jan. 1, 2011
Hizentra[3]	Sept. 1, 2015	Sandostatin (not LAR)	Jan. 1, 2011
Humatrope	Jan. 1, 2011	Serostim	Jan. 1, 2011
Humira	Jan. 1, 2011	Siliq	July 1, 2021
HyQvia	Sept 12, 2014	Simponi (does not include Simponi Aria)	Jan. 1, 2011
Ilaris	Jan. 1, 2011	Skytrofa	Oct 21, 2021
Increlex	Jan. 1, 2011	Somavert	Jan. 1, 2011
Infergen	Jan. 1, 2011	Stelara (not IV form)	Jan. 1, 2011
Kesimpta	Sept 1,2020	Strensiq	July 1, 2021
Kevzara	July 1, 2021	Supartz[2]	Jan. 1, 2011
Kineret	Jan. 1, 2011	Synvisc[2] (all forms)	Jan. 1, 2011
Leuprolide (non-Depot form)	Jan. 1, 2011	Tegsedi	July 1, 2021
Luveris	Jan. 1, 2011	Teriparatide	Mar 1, 2020
Menopur	Jan. 1, 2011	Tev-Tropin	Jan. 1, 2011
Monovisc[2]	July 1, 2021	Tezspire	Jan 13, 2022
Myobloc[3]	Sept. 1, 2015	TOBI	Jan. 1, 2011

Medication	Date added to this list	Medication	Date added to this list
Tremfya	July 1, 2021	Visco-3[2]	Jan. 1, 2011
Triluron	July 1, 2021	Xeomin[3]	Sept. 1, 2015
Trivisc	July 1, 2021	Xgeva[3]	Sept. 1, 2015
Tymlos	Jan. 1, 2011	Zorbtive	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
1/2022	Updated to add Tezspire to the policy.
10/2021	Updated to add Skytrofa to the policy.
7/1/2021	Updated to add 7/1 changes and for maintenance and clean up.
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