



MASSACHUSETTS

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Pharmacy Medical Policy

Sublingual Immunotherapy with Allergen-specific Extracts (SLIT)

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Policy Number: 681

BCBSA Reference Number: None

Related Policies

- Quality Care Dosing guidelines apply to the following medications and can be found in Medical Policy #621A

Policy

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

Note: All requests for outpatient retail pharmacy only (**ALL SLIT PRODUCTS ARE EXCLUDED FROM MAIL ORDER**) 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 and step status of the medications affected by this policy.

Drug	Formulary Information
	Standard
	Formulary Status
GRASTEK®	PA Required
ODACTRA™	PA Required
ORALAIR®	PA Required
RAGWITEK™	PA Required

We may cover at retail pharmacy only Grastek® when **all** of the following criteria are met¹:

- Prescribed by a board certified or board eligible allergist or board certified or board eligible Otolaryngologists

OR

- Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies;

AND

- Grastek® is an allergen extract indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis caused by Timothy grass or cross-reactive grass pollens;

AND

- For use in persons 5 through 65 years of age.

*Approvals for treatment when provided are limited to start the time period needed before the expected onset of the allergy-inducing pollen season and continued throughout the pollen season.

We may cover at retail pharmacy only **Odactra™** when **all** of the following criteria are met:

- Prescribed by a board certified or board eligible allergist or board certified or board eligible Otolaryngologists

OR

- Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies;

AND

- **Odactra™** is an allergen extract indicated as immunotherapy for treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis;

AND

- For use in persons 18 through 65 years of age.

*Approvals for treatment when provided are limited to start the time period needed before the expected onset of the allergy-inducing pollen season and continued throughout the pollen season.

We may cover at retail pharmacy only Oralair® when **all** of the following criteria are met¹:

- Prescribed by a board certified or board eligible allergist or board certified or board eligible Otolaryngologists

OR

- Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies;

AND

- Oralair® is an allergen extract indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis;

AND

- For use in persons 10 through 65 years of age.

*Approvals for treatment when provided are limited to start the time period needed before the expected onset of the allergy-inducing pollen season and continued throughout the pollen season.

We may cover at retail pharmacy only Ragwitek™ when **all** of the following criteria are met¹:

- Prescribed by a board certified or board eligible allergist or board certified or board eligible Otolaryngologists

OR

- Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies;

AND

- Ragwitek™ is an allergen extract indicated as immunotherapy for treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis;

AND

- For use in persons five (5) through 65 years of age.

*Approvals for treatment when provided are limited to start the time period needed before the expected onset of the allergy-inducing pollen season and continued throughout the pollen season.

**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 the above drugs for other conditions not listed above.

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

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
7/2021	Updated to increase Ragwitek's age indication with FDA update.
4/2020	Clarified prescribing specialists for all SLITs.
3/2018	Updated to include Odactra™
6/2017	Updated address for Pharmacy Operations.
4/2017	Added criteria for Otolaryngologists.
8/2015	Updated approved ages for Oralair®
10/2014	Implemented New policy.

References

1. GRASTEK® [package insert]. Whitehouse Station, NJ: Merck & CO., Inc.: 2014.
2. ORALAIR® [package insert]. St-Laurent, Quebec: Paladin Labs., Inc.: 2014.
3. RAGWITEK™ [package insert]. Whitehouse Station, NJ: Merck & CO., Inc.: 2014.

4. ODACTRA™ [package insert]. Swindon, Wiltshire, SN5 8RU UK: Catalent Pharma Solutions Limited: Jan 2018.

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>