BOSTON MEDICAL CENTER HEALTHNet PLAN

WELL SENSE HEALTH PLAN

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Pharmacy Policy

Glucagon Products – Unified Formulary

Policy Number: 9.333
Version Number: 2
Version Effective Date: 9/1/2021

Product Applicability

☐ **All Plan+ Products**

Well Sense Health Plan

☐ New Hampshire Medicaid

Boston Medical Center HealthNet Plan

☒ MassHealth ACO

☒ MassHealth MCO

☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct

☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy

Reference Table:

Drugs that require PA	No PA
Gvoke® (glucagon auto-injection, prefilled syringe)	Baqsimi® (glucagon nasal powder)[PD]

[PD]Preferred Drug. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.

Procedure:

Approval Diagnosis:	• Diabetes mellitus
Approval Criteria: **Gvoke®** (glucagon auto-injection, prefilled syringe)	Prescriber provides documentation of **ALL** of the following: 1. Appropriate diagnosis 2. **ONE** of the following: a. Member ≥2 years and <4 years b. Inadequate response, adverse reaction or contraindication to Baqsimi® (glucagon nasal powder) *(History of claims is not sufficient*)
Denial Criteria:	Cases that do not meet the approval criteria will be denied. If a request is denied and the prescriber has additional clinical

	documentation, a **new** prior authorization request must be submitted.
Duration/Quantity of Authorization:	Prior authorization may be issued for **1 year.**
Recertification Criteria:	Resubmission by prescriber will infer a positive response to therapy and request can be recertified for 1 year.

Appendix:

Stability

Stability on a medication requiring a prior authorization is not a reason to bypass approval criteria.

Grandfathering

Information is not applicable

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	Created policy for MH Partial Unified Formulary	1/1/2021	P&T Committee
5/13/2021	Annual policy review, no changes	9/1/2021	P&T Committee

Next Review Date

5/2022

Other Applicable Policies

References

Reference to Applicable Laws and Regulations, if Any

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