Pharmacy Policy

Non-Preferred Blood Glucose Testing Products

Policy Number: 9.320
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 – MCO
☐ MassHealth – ACO
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☐ Senior Care Options

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

Policy Summary

The Plan will authorize coverage of non-preferred brand-name glucometers and blood glucose test strips when appropriate criteria are met.

Description of Item or Service

Upon evaluation of currently available diabetes glucometer products in the market, it has been determined that they are comparable in features tailored for specific needs and test outcomes delivered. Given that there is a lack of evidence supporting the superiority of one glucometer product and associated blood glucose test strips over another, The Plan will cover Freestyle® and Precision Xtra® glucometers and blood glucose test strips. Multiple products with a variety of functions are available within the Freestyle® and Precision Xtra® product line to ensure that the needs and the quality of care for the member are met. The accuracy of blood glucose tests relies mainly on manual operation and can be improved by user education.

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Policy

The Plan may authorize coverage of non-preferred brand-name glucometers and blood glucose test strips for members meeting the following criteria:

Prior Authorization – (Duration of Approval – Maximum of 2 years)

Freestyle® and Precision Xtra® glucometers and blood glucose test strips **are covered by the Plan**. A prior authorization request will be required for coverage of all other brand-name glucometers and blood glucose test strips. These requests will be approved when the following criteria are met:

Documentation of the following:

1. A specific function of the requested product is not available in a Freestyle® or Precision Xtra® product (provide the functions that are needed); ***AND***
2. A clinical reason why this specific function is critical for adequate self-monitoring of the member's blood glucose.

Limitations

The Plan will *not* approve coverage of non-preferred brand-name glucometers and blood glucose test strips in the following instances:

1. When the above criteria are not met.

*The Plan does not cover product maintenance items such as batteries and calibration solutions.

Clinical Background Information and References

N/A

Appendix A – Quantity Limitations for Blood Glucose Testing Products

Medication	Quantity Limitation
Blood Glucose Test Strips	200 per 30 days
Blood Glucose Meter	1 per 365 days
Freestyle Libre/Libre 2 Reader	1 per 365 days
Freestyle Libre/Libre 2 Sensor	2 per 28 days

Original Approval Date	Original Effective Date	Policy Owner	Approved by
9/10/2020	1/1/2021	Pharmacy Services	P&T Committee

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Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
9/10/2020	9.172 Blood Glucose Testing Products Policy retired, new policy created. Clarified language, added Libre 2 to policy, added limitation note that plan does not cover maintenance items	1/1/2021	P&T Committee
5/13/2021	P&T Annual Review: No changes	9/1/2021	P&T Committee

Next Review Date

5/2022

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with

applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.