BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Beta Blockers

Policy Number: 9.602
Version Number: 2
Version Effective Date: 3/1/2022

Product Applicability	☐ **All Plan+ Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☐ New Hampshire Medicaid	☒ 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.

Prior Authorization Policy

Products Affected:

- **Hemangeol (propranolol)**
- **Sotylize (sotalol)**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications unless otherwise excluded
Exclusion Criteria	Hemangeol 1. Premature infants with corrected age of less than 5 weeks 2. Member weighs less than 2 kilograms 3. Member has contraindications to treatment (e.g., history of pheochromocytoma, blood pressure less than 50/30 mmHg, etc.)

+ *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.

Required Medical Information	Hemangeol 1. Diagnosis of proliferating infantile hemangioma requiring systemic therapy. Sotylize 1. A diagnosis of life-threatening ventricular arrhythmias or highly symptomatic atrial fibrillation or atrial flutter; **AND** 2. Inadequate response or intolerance to generic sotalol tablets; ***OR*** 3. Member has difficulty swallowing tablets
Age Restrictions	Hemangeol: Member is between 5 weeks to 5 months
Prescriber Restriction	None
Coverage Duration	12 months
Other criteria	Sotylize Reauthorization criteria: 1. Member has difficulty swallowing tablets

Clinical Background Information and References

1. James PA. 2014 Evidence-based guidelines for the management of high blood pressure in adults. Report from the panel members appointed to the Eighth Joint National Committee (JNC 8). JAMA. 2014;311(5):507-520
2. Yancy CW. 2013 ACCF/AHA guideline for the management of heart failure. Circulation. 2013;128(16);e240-e327
3. Product Information: Hemangeol™, propranolol oral solution. Pierre Fabre Pharmaceutics, Inc, Parsippany, NJ, 2014
4. Product Information: Sotylize™, sotalol oral solution. Arbor Pharmaceuticals, Atlanta, GA, 2015.
5. Hogeling M, Adams S, Wargon O. A randomized controlled trial of propranolol for infantile hemangiomas. Pediatrics. 2011;128:e259-e266.
6. Metry DW. Management of infantile hemangiomas. UpToDate. Last updates March 9, 2015. Accessed April 16, 2015. Available at www.uptodate.com.

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	9.164 Beta Blockers Policy retired, new policy created	1/1/2021	P&T Committee
11/11/2021	Annual review: reworded reauthorization criteria	3/1/2022	P&T Committee

Next Review Date

11/2022

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.