BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Step Therapy – Antidiabetic Agents

Policy Number: 9.327
Version Number: 1.1
Version Effective Date: 1/1/2021

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

POLICY STATEMENT:
A step therapy program has been developed to encourage the use of Step-1 products prior to the use of a Step-2 product, without interrupting existing therapy. If the step therapy rule is not met for a Step-2 agent at the point of service, coverage will be determined by the step therapy criteria below. All approvals are provided for 1 year in duration.

Standard Criteria:
The Plan May Authorize Coverage Of The Products in Appendix A For Members Meeting The Following Criteria When Step Therapy Is Not Met At Point Of Sale From Claims History:

1. Prescribers must provide documentation that the member has tried and failed *the* trial requirements in the Step-1 category, then authorization for a Step-2 product may be given. **OR**

2. Prescriber attestation is provided that member has had an inadequate response, intolerance Or Contraindication to Appropriate Step-1 Agents or Step-2 Agents as Indicated in Appendix A. **OR**
3. For Members who are new to the plan without prior claims history, prescribers must provide documentation, including applicable dates, of prior use of a Step-1 and/or Step-2 drug to continue treatment.

Appendix A: Step Therapy Details

Antidiabetics – SGLT-2 Agents		
Step 1	**Step 2**	**Coverage Criteria**
Metformin IR/XR Metformin combination products	Jardiance Synjardy IR/XR	A Step 2 medication will be covered when pharmacy claims are present for a Step 1 medication within the last 130 days.

Antidiabetics – DDP4 Agents		
Step 1	**Step 2**	**Coverage Criteria**
Metformin IR/XR Metformin combination products	Janumet IR/XR Januvia Jentadueto IR/XR Tradjenta	A Step 2 medication will be covered when pharmacy claims are present for a Step 1 medication within the last 130 days.

Antidiabetics – Combination Agents		
Step 1	**Step 2**	**Coverage Criteria**
Metformin IR/XR Tablet Metformin combination products	Glyxambi Trijardy XR	A Step 2 medication will be covered when pharmacy claims are present for a Step 1 medication within the last 130 days.

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

Policy Revisions History

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
9/10/2020	P&T Committee Review. 9.087 Step Therapy Policy retired, new policy created. Updated policy to align with 2021 formulary Changed approval duration from 2 to 1 year. Changed trial duration from 120 to 130 days.	1/1/2021	P&T Committee
02/23/2021	Removed Invokana and Invokamet IR /XR from physical policy as this was removed from formulary and made non-formulary for QHP at the September 10, 2020 P&T meeting but never was removed.	1/1/2021	P&T Committee (9/10/2020)

Next Review Date

2021

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.