BOSTON MEDICAL CENTER HEALTHNet PLAN

bmchp.org | 888-566-0008

Pharmacy Policy

Turalio® - Unified Formulary

Policy Number: 9.717
Version Number: 2.0
Version Effective Date: 9/1/2021

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

Reference Table:

Drugs that require PA	No PA
Turalio® (pexidartinib)	

Procedure:

Approval Diagnosis:	• Tenosynovial Giant Cell Tumor
Approval Criteria:	Prescriber provides documentation of **ALL** of the following: 1. Appropriate diagnosis 2. Member ≥18 years of age 3. Prescriber is an oncologist 4. Appropriate dosing 5. Member is not a candidate for surgery
Denial Criteria:	Cases that do not meet the approval criteria will be denied.

+ *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.

	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 **3 months**
Recertification Criteria:	Resubmission by prescriber will infer a positive response to therapy and request can be recertified for **up to 3 months**

Appendix:

Stability

Stability alone on Turalio® (pexidartinib) is not a reason to bypass approval criteria. However, requests for members who have already started treatment on these agents should be reviewed with clinical review and approval is strongly considered for any member with any FDA-approved indication.

Grandfathering

Information is not applicable.

Additional Information

Clinical Background Information and References

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	New policy created to align with MH Unified Formulary Policy	1/1/2021	P&T Committee
5/13/2021	No recommended criteria changes or updates.	9/1/2021	P&T Committee

Next Review Date

5/2022

[+] *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.

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.