BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Step Therapy Policy – Misc. Ophthalmic Policy

Policy Number: 9.915
Version Number: 2.0
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
	☐ 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 generic Step-1 products prior to the use of a Step-2 or Step-3 product, without interrupting existing therapy. If the step therapy rule is not met for a Step-2 or Step-3 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 the appendix for all FDA indications not otherwise excluded and for members meeting the following criteria when step therapy is not met at point of sale from claims history:

1. Prescribers must provide documentation (including trial outcome) that the member has tried and failed the appropriate number of Step 1 agents as indicated in Appendix A and in the coverage criteria requirements. **OR**

+ *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.

2. Prescriber must provide documentation that the member has a contraindication to or other clinical rationale preventing the use of ALL Step 1 agents indicated in Appendix A.

Appendix A: Step Therapy Details

Ophthalmic - Allergy			
Step 1	**Step 2**	**Step 3**	**Coverage Criteria**
Ketotifen 0.025% Cromolyn 4% Soln Diclofenac 0.1% Soln Flurbiprofen 0.03% Soln. Dexamethasone 0.1% Ketorolac 0.4% Soln Ketorolac 0.5% Soln Prednisolone 1% Pred Mild 0.12% Fluorometholone Susp 0.1%	Azelastine Hcl 0.05% Epinastine Hcl 0.05% Bromfenac 0.9% Difluprednate 0.05% Emulsion Loteprednol 0.5% Susp	Olopatadine 0.1%	**Step 2:** Pharmacy Claims Indicating The Use of One Step 1 agent In The Past 130 Days or meets above criteria **Step 3:** Pharmacy Claims Indicating The Use of One Step 1 agent And One Step 2 Agent In The Past 130 Days or meets above criteria

Ophthalmic – Anti-Inflammatory		
Step 1	**Step 2**	**Coverage Criteria**
Cromolyn Sodium Soln 4% Dexamethasone 0.1% Fluorometholone 0.1% Prednisolone 1%	Difluprednate 0.05% Emulsion Loteprednol 0.5% Opth Gel	Pharmacy Claims Indicating The Use of One Step 1 agent In The Past 130 Days or meets above criteria

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

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Policy Revisions History			
Review Date	**Summary Of Revisions**	**Revision Effective Date**	**Approved By**
12/1/2020	Created separate policies per applicable line of business. Coverage duration changed to 1 year. Addition of policy statement and standard criteria. Changed trial look back to 130 days from 120 days.	1/1/2021	P&T Committee
11/11/2021	Update step therapy coverage criteria to align with all other step policies. Change Ketorolac 0.4% And 0.5% Ophthalmic Soln. from Step 2 agents to Step 1 agents.	3/1/2022	P&T Committee

Next Review Date

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.