Pharmacy Policy

Blood Glucose Testing Products

Policy Number: 9.172
Version Number: 8.0
Version Effective Date: 01/01/2018

Product Applicability  □ All Plan+ Products

Well Sense Health Plan
- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan
- MassHealth
- 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.
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 provided by the requested product that is not available in a Freestyle® and a Precision Xtra® product; 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.

Clinical Background Information and References

N/A

Appendix A – Quantity Limitations for Blood Glucose Testing Products

<table>
<thead>
<tr>
<th>Medication</th>
<th>Quantity Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Test Strips</td>
<td>200 per 30 days</td>
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<tr>
<td>Blood Glucose Meter</td>
<td>1 per 365 days</td>
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</table>

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>08/26/2011</td>
<td>08/26/2011</td>
<td>Pharmacy Services</td>
<td>Pharmacy &amp; Therapeutics (P&amp;T) Committee</td>
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<tr>
<td>08/22/2012</td>
<td>12/01/2013</td>
<td>Pharmacy Services</td>
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* 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.

Blood Glucose Testing Products

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### Policy Revisions History

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<th>Summary of Revisions</th>
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<th>Approved by</th>
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<tr>
<td>9/13/2012</td>
<td>P&amp;T Annual Review, no criteria changes required</td>
<td>01/01/2013</td>
<td>P&amp;T Committee</td>
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<tr>
<td>9/12/2013</td>
<td>P&amp;T Annual Review, minor formatting and title change, no criteria changes required</td>
<td>01/01/2014</td>
<td>P&amp;T Committee</td>
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<tr>
<td>12/13/2013</td>
<td>Policy applied to ConnectorCare/Qualified Health Plan (QHP)</td>
<td>04/01/2014</td>
<td>P&amp;T Committee</td>
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<tr>
<td>09/11/2014</td>
<td>P&amp;T Annual Review, no criteria changes required</td>
<td>01/01/2015</td>
<td>P&amp;T Committee</td>
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<td>09/10/2015</td>
<td>P&amp;T Annual Review, no criteria changes required</td>
<td>01/01/2016</td>
<td>P&amp;T Committee</td>
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<tr>
<td>09/08/2016</td>
<td>P&amp;T Annual Review, no criteria changes required</td>
<td>01/01/2017</td>
<td>P&amp;T Committee</td>
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<td>09/14/2017</td>
<td>P&amp;T Annual Review, no criteria changes required</td>
<td>01/01/2018</td>
<td>P&amp;T Committee</td>
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### Next Review Date

09/13/2018

### Other Applicable Policies

9.002 Mandatory Generic Substitution Policy
9.015 Quantity Limitation Policy
OCA 3.14 Medically Necessary Policy

### 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 agencies.

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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.

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