



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy Injectable Specialty Medication Coverage

Table of Contents

- [Policy: Commercial](#)
- [Policy: Medicare](#)
- [Coding Information](#)
- [Policy History](#)
- [Information Pertaining to All Policies](#)
- [References](#)
- [Endnotes](#)
- [Forms](#)

Policy Number: 071

BCBSA Reference Number: None

Related Policies

- Quality Care Dosing guidelines may apply to the following medications and can be found in Medical Policy #[621A](#)
- Medical Utilization Management (MED UM) Policy #[033](#)

Prior Authorization Information

| | | |
|--|--|--|
| <input type="checkbox"/> Prior Authorization <input type="checkbox"/> Step Therapy <input type="checkbox"/> Quality Care Dosing <input checked="" type="checkbox"/> Benefits | | Pharmacy Operations: Tel: 1-800-366-7778 Fax: 1-800-583-6289 Policy last updated 1/2024 |
| Pharmacy (Rx) or Medical (MED) benefit coverage | <input checked="" type="checkbox"/> Rx <input type="checkbox"/> MED | To request for coverage: Physicians may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below. |
| Policy applies to Commercial Members: <ul style="list-style-type: none"> • Managed Care (HMO and POS), • PPO and Indemnity • Managed Major Medical with Custom BCBSMA Formulary • Comprehensive Managed Major Medical with Custom BCBSMA Formulary • Managed Blue for Seniors with Custom BCBSMA Formulary | | Blue Cross Blue Shield of Massachusetts Pharmacy Operations Department 25 Technology Place Hingham, MA 02043 |

This policy applies to all members, except:

- Medicare Advantage members
- Federal Employee Program members
- Members with Medicare Supplemental Plans

Injectable Specialty Medication Coverage Information

(As of January 1, 2020)

The medications included in this policy are covered under the member's pharmacy benefits only when filled through a specialty pharmacy in our network. Exceptions are noted where applicable in the medication list on the following pages. A valid prescription from a licensed health care provider is required to fill these medications.

Some medications may also be subject to other pharmacy management programs, such as Step Therapy, Prior Authorization, or Quality Care Dosing, or have other coverage requirements. For more information about these medications, use our Medication Lookup tool:

- Medication Lookup for Providers: bluecrossma.com/provider
- Medication Lookup for Members: bluecrossma.com/medications

Important: Providers can't buy and bill us for the medications listed in this policy using the member's medical benefits. (There are exceptions for providers in Massachusetts to buy and bill certain medications that are noted on the list.)

Additional Coverage Information

| | Medications Self-Administered at Home | Medications Administered in a Doctor's Office | Medications Administered by a Home Infusion Therapy Provider |
|----------------------------------|---|--|--|
| Ordering the Medication | The prescriber orders the medication through an in-network retail specialty pharmacy. | The prescriber orders the medication through an in-network retail specialty pharmacy for delivery to the prescriber's office or an outpatient clinic for administration. | The prescriber requests prior authorization for this service. They refer the member to a home infusion therapy provider who procures the medication and administers it in the member's home. |
| Paying for the Medication | The member is responsible for out-of-pocket prescription costs, such as a copay, deductible, or co-insurance. | The member is responsible for any prescription costs (such as a copay, deductible, or co-insurance) and the cost of the office visit (such as a copay, | The member is responsible for any applicable cost sharing outlined under the home care benefit (such as a copay, deductible, or co-insurance). |

| | | | |
|--|--|-------------------------------|--|
| | | deductible, or co-insurance). | |
|--|--|-------------------------------|--|

List of Medications Covered Only Under the Pharmacy Benefit¹

This isn't a complete list of covered medications, and inclusion on the list doesn't guarantee coverage. Some members, depending on their pharmacy plan, may not be covered for these medications. Providers should check a member's eligibility and benefits.

| Medication | Date added to this list | Medication | Date added to this list |
|-----------------------------|-------------------------|-------------------------------|-------------------------|
| Actimmune | Jan. 1, 2011 | Follistim AQ | Jan. 1, 2011 |
| Abrilada | Jan. 1, 2024 | Forteo | Jan. 1, 2011 |
| Adalimumab-adaz | Jan. 1, 2024 | Fuzeon | Jan. 1, 2011 |
| Adalimumab-adbm | Jan. 1, 2024 | Gamastan SD ³ | Sept. 1, 2015 |
| Adalimumab-fkjp | Jan. 1, 2024 | Gammagard liquid ³ | Sept. 1, 2015 |
| Amjevita | Feb. 8, 2023 | Gammaplex ³ | Sept. 1, 2015 |
| Aranesp | Jan. 1, 2011 | Gamunex ³ | Sept. 1, 2015 |
| Arcalyst | Jan. 1, 2011 | Gamunex-C ³ | Sept. 1, 2015 |
| Avonex | Jan. 1, 2011 | Gammaked ³ | Sept. 1, 2015 |
| Betaseron | Jan. 1, 2011 | Ganirelix | Jan. 1, 2011 |
| Bivigam ³ | Sept. 1, 2015 | Gel-One ² | Jan. 1, 2011 |
| Botox ³ | Sept. 1, 2015 | Gel-Syn ² | Jan. 1, 2011 |
| Bravelle | Jan. 1, 2011 | GelSyn-3 ² | July 1, 2021 |
| Bimzelx | Nov. 2, 2023 | Genotropin | Jan. 1, 2011 |
| Bynfezia | July 1, 2021 | Genvisc | Jan. 1, 2011 |
| Carimune ³ | Sept. 1, 2015 | Glatiramer | Oct. 3, 2017 |
| Cetrotide | Jan. 1, 2011 | Glatopa | Apr. 16, 2015 |
| Chorionic Gonadotropin | Jan. 1, 2011 | Gonal F | Jan. 1, 2011 |
| Cimzia | Jan. 1, 2011 | Gonal F RFF | Jan. 1, 2011 |
| Cyltezo | Jan. 1, 2024 | Hizentra ³ | Sept. 1, 2015 |
| Copaxone | Jan. 1, 2011 | Humatrope | Jan. 1, 2011 |
| Copegus | Jan. 1, 2011 | Humira | Jan. 1, 2011 |
| Cosentyx | July 1, 2021 | Hyrimoz | Jan. 1, 2024 |
| Daxxify | Jan. 1, 2024 | HyQvia ³ | Sept 12, 2014 |
| Dupixent | July 1, 2021 | Idacio | Jan. 1, 2024 |
| Durolane | Mar 5, 2018 | Ilaris | Jan. 1, 2011 |
| Dysport ³ | Sept. 1, 2015 | Ilumya | July 1, 2023 |
| Enbrel | Jan. 1, 2011 | Increlex | Jan. 1, 2011 |
| Enspryng | Sept. 1, 2020 | Infergen | Jan. 1, 2011 |
| Epogen | Jan. 1, 2011 | Kesimpta | Sept 1, 2020 |
| Euflexxa ² | Jan. 1, 2011 | Kevzara | July 1, 2021 |
| Extavia | Jan. 1, 2011 | Kineret | Jan. 1, 2011 |
| Fasenra | July 1, 2021 | Leuprolide (non-Depot form) | Jan. 1, 2011 |
| Flebogamma ³ | Sept. 1, 2015 | Leqvio | Jan. 1, 2023 |
| Flebogamma Dif ³ | Sept. 1, 2015 | Luveris | Jan. 1, 2011 |

| Medication | Date added to this list | Medication | Date added to this list |
|--------------------------|-------------------------|----------------------------------|-------------------------|
| Menopur | Jan. 1, 2011 | Saizen | Jan. 1, 2011 |
| Monovisc ² | July 1, 2021 | Sandostatin (not LAR) | Jan. 1, 2011 |
| Myobloc ³ | Sept. 1, 2015 | Serostim | Jan. 1, 2011 |
| Nordiflex | Jan. 1, 2011 | Siliq | July 1, 2021 |
| Norditropin | July 1, 2021 | Simponi | Jan. 1, 2011 |
| Nucala | Jan. 1, 2011 | Simponi Aria | Jan 1, 2024 |
| Nutropin | Jan. 1, 2011 | Skyrizi | July 1, 2023 |
| Nutropin AQ | Jan. 1, 2011 | Skytrofa | Oct 21, 2021 |
| Octagam ³ | Sept. 1, 2015 | Sogroya | July 1, 2023 |
| Octreotide (not LAR) | Jan. 1, 2011 | Somavert | Jan. 1, 2011 |
| Omnitrope | Sept. 1, 2015 | Stelara | Jan. 1, 2011 |
| Orfadin | Jan. 1, 2011 | Stelara [®] IV | Jan 1, 2024 |
| Orthovisc ² | Jan. 1, 2021 | Strensiq | July 1, 2021 |
| Ovidrel | Jan. 1, 2011 | Supartz ² | Jan. 1, 2011 |
| Panglobulin ³ | Jan. 1, 2011 | Synvisc ² (all forms) | Jan. 1, 2011 |
| Panretin | Jan. 1, 2011 | Tegsedi | July 1, 2021 |
| Panzyga | Jan. 1, 2011 | Teriparatide | Mar 1, 2020 |
| Pegasys | Sept. 1, 2015 | Tev-Tropin | Jan. 1, 2011 |
| PegIntron | Jan. 1, 2011 | Tezspire | Jan 13, 2022 |
| PegIntron Redi Pen | Sept. 1, 2015 | TOBI | Jan. 1, 2011 |
| Pregnyl | Jan. 1, 2011 | Tremfya | July 1, 2021 |
| Privigen ³ | Jan. 1, 2011 | Triluron | July 1, 2021 |
| Procrit | Jan. 1, 2011 | Trivisc | July 1, 2021 |
| Prolia ³ | Jan. 1, 2011 | Tymlos | Jan. 1, 2011 |
| Pulmozyme | Sept. 1, 2015 | Visco-3 ² | Jan. 1, 2011 |
| Rebetol | Jan. 1, 2011 | Xeomin ³ | Sept. 1, 2015 |
| Rebetron | Jan. 1, 2011 | Xgeva ³ | Sept. 1, 2015 |
| Rebif | Jan. 1, 2011 | Yuflyma | Jan 1, 2024 |
| Remicade ³ | Jan. 1, 2011 | Zorbtive | Jan. 1, 2011 |
| Repronex | Jan. 1, 2011 | | |
| RibaPak | Jan. 1, 2011 | | |
| Ribasphere | Jan. 1, 2011 | | |
| Ribavirin | Jan. 1, 2011 | | |

Footnotes

1. Does not apply when the medication is administered: in the emergency room; as an inpatient; at a surgical day care facility; in an ambulatory surgery center; or through home infusion therapy or dialysis.
2. This medication can be filled at any retail pharmacy. The member doesn't need to use a retail specialty pharmacy in our network for these medications only.
3. These medications are covered under the *pharmacy benefit* when filled at an in-network specialty pharmacy. However, they may be covered under the *medical benefit* by a doctor who practices in Massachusetts and administered based on the member's benefits.

Policy History

| Date | Action |
|----------|---|
| 1/2024 | Updated to add Stelara [®] IV and Simponi Aria [®] to the policy. |
| 7/2023 | Reformatted Policy and Added Sogroya [®] to the policy |
| 1/2023 | Updated to add Leqvio [®] to the policy. |
| 1/2022 | Updated to add Tezspire to the policy. |
| 10/2021 | Updated to add Skytrofa to the policy. |
| 7/1/2021 | Updated to add 7/1 changes and for maintenance and clean up. |
| 9/1/2020 | Updated to add Kesimpta and Enspryng to the policy. |
| 3/1/2020 | Policy developed based on current process. |

To request Prior Authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

<http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf>