

For brokers and producers only

Date: August 20, 2020

Markets: All (except FEP and Medicare Supplement members)

## 2020 Rx Enhancements

### Medical Pharmacy Management (MPM)

Effective **October 1, 2020**, the medications listed below covered under the medical benefit will require prior authorization and/or site of care to better manage rising specialty drug costs. Impacted members will be notified via letter by September 1 and providers will be notified in the August issue of BlueLink.

Prior authorization is required to ensure safe and effective use of these high-cost medications. Through prior authorization, site of care criteria is applied for selected medications as an opportunity to help reduce overall healthcare costs without compromising quality of care. The outpatient hospital setting is generally recognized as one of the most costly options for specialty infusions with costs up to three times higher compared to non-hospital settings.

To view a full list of medications covered under the medical benefit that require prior authorization or subject to site of care, visit the [Specialty Drug List](#). This list is updated monthly.

#### Prior Authorization

Drug Name	Drug Class	Drug Name	Drug Class
<b>Actimmune</b>	Infectious Disease - Other	<b>Lupaneta Pack</b>	Hormonal Therapies
<b>Asceniv</b>	Immune Deficiencies and Related Disorders	<b>Myalept</b>	Lipodystrophy
<b>Avsola</b>	Autoimmune	<b>Neulasta</b>	Neutropenia
<b>Azactidine (Vidaza)</b>	Oncology	<b>Nivestym</b>	Neutropenia
<b>Belrapzo (bendamustine)</b>	Oncology	<b>Octreotide</b>	Acromegaly
<b>Corifact</b>	Hemophilia	<b>Ontruzant</b>	Oncology

<b>Cosentyx</b>	Autoimmune	<b>Padcev</b>	Oncology
<b>Cutaquig</b>	Immune Deficiencies and Related Disorders	<b>Scenesse</b>	Rare Disorders
<b>Enhertu</b>	Oncology	<b>Sylatron</b>	Oncology
<b>Esperoct</b>	Hemophilia	<b>Tepezza</b>	Retinal Disorders
<b>Fulphilia</b>	Neutropenia	<b>Tobramycin (inhalation solution)</b>	Cystic Fibrosis
<b>Gamifant</b>	Rare Disorders	<b>Trazimera</b>	Oncology
<b>Givlaari</b>	Rare Disorders	<b>Tretten</b>	Hemophilia
<b>Herzuma</b>	Oncology	<b>Tyvaso</b>	Pulmonary Arterial Hypertension
<b>Increlex</b>	IGF-1 Deficiency	<b>Vyondys 53</b>	Muscular Dystrophy
<b>Infugem</b>	Oncology	<b>Zirabev</b>	Oncology

Failure to obtain prior authorization for these drugs may result in the denial of the claim payment.

#### Site of Care

<b>Drug Name</b>	<b>Drug Class</b>	<b>Drug Name</b>	<b>Drug Class</b>
<b>Asceniv</b>	Immune Deficiencies and Related Disorders	<b>Nucala</b>	Asthma
<b>Avsola</b>	Autoimmune	<b>Ocrevus</b>	Multiple Sclerosis
<b>Cinqair</b>	Asthma	<b>Tepezza</b>	Retinal disorders

<b>Cinryze</b>	Hereditary Angioedema	<b>Xolair</b>	Asthma
<b>Fasenra</b>	Asthma		

Coverage for these medications at an outpatient hospital setting is approved only if medical necessity criteria are met at the time of prior authorization. Members have the option to receive their infusion at an alternate site including their home, an ambulatory infusion center or a physician's office.

**For more information**

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