Department of Origin: Pharmacy	**Effective Date:** 07/26/2023
Approved by: Chief Medical Officer	**Date Approved:** 07/26/2023
Pharmacy Clinical Policy Document: Cost Benefit Program	**Replaces Effective Policy Dated:** 08/1/2022
Reference #: PP/C002	**Page:** 1 of 3

PURPOSE:
The intent of this pharmacy clinical policy is to provide coverage guidelines for the Cost Benefit Program.

Please refer to the member's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the member's benefit plan or certificate of coverage, the terms of the member's benefit plan document will govern.

Drug Label Name	HCPCS Code	Generic Description
H.P. Acthar Gel	J0800	Repository Corticotropin
Cortrophin gel	J3490 (NOC)	Repository Corticotropin
Makena	J1726	Hydroxyprogesterone Caproate injection
Quzyttir	J1201	Cetirizine hydrochloride injection
Susvimo	J2779	Ranibizumab, intravitreal implant

POLICY:
The plan requires the use of the most safe, efficacious, and cost-effective medication when therapeutic alternatives are available.

Drugs identified by the Cost Benefit Program as excluded have been determined to have no benefit over another formulation.

Many drugs have been developed for convenience issues such as combination drugs to allow one drug to be taken instead of two, extended-release drugs to allow less frequent dosing of medications or different formulations for ease of administration.

When *reliable evidence* does not support the need for a combination, an extended-release formulation, or a new formulation over the existing alternative(s), a drug is considered not cost-effective. These drugs will be listed as excluded on the Cost Benefit Program and use of alternative drugs will be required.

When *reliable evidence* does not support the preference for a drug when compared to a similar drug in the same drug class that demonstrates similar efficacy and safety data and thus, does not justify any significant cost difference, a drug is considered not cost effective. These drugs will also be listed as excluded on the Cost Benefit Program and use of alternative drugs will be required.

Drugs listed on the Cost Benefit Program are considered benefit exclusions. Overrides for drugs on the Cost Benefit Program are not allowed.

Benefits must be available for health care services. Healthcare services must be ordered by a provider. Healthcare services must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

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DEFINITIONS:

Reliable evidence:

The Plan will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether an oncology treatment is included in the applicable National Comprehensive Cancer Network (NCCN) guideline, as appropriate for its proposed use, or whether a drug is included in any authoritative compendia as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment or procedure.

REFERENCES:

1. Medical Management Process Manual UR015 Use of Medical Policy and Criteria
2. Medical Policy: MP/C009 Coverage Determination Guidelines
3. Minnesota State Statute 151.21 Substitution
4. Pharmacy Clinical Policy: PP/F001 Formulary Exceptions
5. Pharmacy Clinical Policy: PP/Q003 Quantity Limits
6. Pharmacy Clinical Policy: PP/T002 Therapeutic Equivalence
7. NCQA 2021 HP Standards and Guidelines UM 11: Procedures for Pharmaceutical Management

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Effective August 16, 2012: This Pharmacy Clinical Policy is no longer annually reviewed.

Effective September 29, 2014: This Pharmacy Clinical Policy (PP/C002) will resume being on an annual review schedule.

DOCUMENT HISTORY:

Created Date: 11/04
Reviewed Date: 08/08/12, 09/29/14, 07/01/15, 03/24/16, 03/24/17, 03/23/18, 06/11/18, 06/11/19, 06/10/20, 6/11/2021, 6/10/2022, 6/1/2023
Revised Date: 08/17/05, 11/15/06, 03/05/07, 04/16/07, 07/30/07, 11/01/07, 11/12/07, 03/17/08, 07/08/08, 08/13/08, 10/21/08, 05/04/09, 07/16/09, 10/28/09, 03/22/10, 07/15/10, 07/28/10, 08/19/10, 09/24/10, 11/11/10, 12/16/10, 01/25/11, 07/05/11, 08/29/11, 10/19/11, 01/03/12, 1/31/12, 05/16/12, 09/18/12, 11/13/12, 12/20/12, 02/01/13, 02/15/13, 08/14/13, 07/31/14, 09/29/14, 01/26/15, 07/08/15, 10/28/15, 03/24/16, 06/30/17, 03/29/21, 7/22/22

Attachment A

Provider-Administered Drugs Affected by Cost Benefit Program

Drug Label Name	Generic Description
H.P. Acthar Gel	repository corticotropin
Cortrophin gel	repository corticotropin
Quzyttir	cetirizine hydrochloride injection
Susvimo	Ranibizumab, intravitreal implant

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:
Provide free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *contract*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1.866.631.5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً . اتصل بن اعلى رقم الهاتف 1.866.631.5404(رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_: य_द आप ि◌हंदी बोलते ह_ तो आपके ि◌लए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 1.866.631.5404 (TTY:711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.866.631.5404 (TTY:711).