



MEDICAL COVERAGE POLICY

SERVICE: Immunological Modifier Medications

Policy Number:	286
Effective Date:	04/01/2021
Last Review:	02/25/2021
Next Review Date:	02/25/2022

Important note:

Unless otherwise indicated, this policy will apply to all lines of business.

Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

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PRIOR AUTHORIZATION: **Varies by plan**

POLICY: SWHP/FirstCare covers the following medications with no preferences within this class:

1. Actemra (tocilizumab)
2. Cimzia (certolizumab pegol)
3. Cosentyx (secukinumab)
4. Enbrel (etanercept)
5. Entyvio (vedolizumab)
6. Humira (adalimumab)
7. Orencia (abatacept)
8. Otezla (apremilast)
9. Simponi (golimumab)
10. Simponia Aria (golimumab)
11. Stelara (ustekinumab)
12. Xeljanz (tofacitinib)

Please refer to medical coverage policy #215 Medications Covered Under Medical Insurance Policy for clinical criteria for coverage. For medications with a non-preferred status, member must meet one of the following criteria with preferred drug(s) in the same class: a) failure of an adequate trial b) clinically significant intolerance c) contraindication.

For infliximab, please refer to the Infliximab Biosimilar Products medical policy.

For rituximab, please refer to the Biosimilar Medications medical policy.

CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.



Scott & White
HEALTH PLAN
 PART OF BAYLOR SCOTT & WHITE HEALTH



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CPT Codes:	
CPT Not Covered:	
HCPCS Codes:	J0129, J0135, J0717, J1438, J1602, J3262, J3357, J3358, J3380
ICD10 codes:	
ICD10 Not covered:	

CMS:

POLICY HISTORY:

Status	Date	Action
New	02/25/2021	New policy