AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Oncology Medications	Page:	1 of 3
Effective Date:	5/1/2024	Last Review Date:	6/15/2023. 3/2024

Applies to:	☒Illinois	☐Florida	☐Florida Kids
	☒New Jersey	☒Maryland	☐Michigan
	☒Pennsylvania Kids	☒Virginia	☐Texas

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for oncology drugs under the patient's prescription drug benefit.

Description:

Oncology indications including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

All other indications are considered experimental/investigational and not medically necessary.

Drug List:

Reference formulary for specific oncology medications

Policy/Guideline:

Submission of the following information is necessary to initiate the prior authorization review:

A. Medical records, lab results, test results, and clinical markers supporting the diagnosis and treatment
B. If a test with adequate ability to confirm a disease mutation exists, documentation that the test was performed to confirm the mutation
C. Results of required genetic testing (as applicable based on FDA-approved labeling)

The oncology medication must be prescribed by or in consultation with an Oncologist or Hematologist.

Authorization of 3 months may be granted for treatment of an oncology indication when both of the following criteria are met:

1. Medication is prescribed for an FDA-approved indication OR for a "medically accepted indication" as supported by the following Compendia:
    i. National Comprehensive Cancer Network (NCCN) Drugs and Biologic Compendium or NCCN Clinical Practice Guidelines (Category 1, 2a, or 2b)
    ii. Micromedex DrugDex
    iii. Clinical Pharmacology

2. Requests for non-preferred or non-formulary medications must meet one of the following:
    i. Member has an inadequate response or intolerable adverse event to all of the formulary preferred agents (based on FDA-approved labeling and NCCN Clinical Practice Guidelines)
    ii. Member has a contraindication or a clinical reason to avoid all of the formulary preferred agents
    iii. There are no formulary preferred medications for the patient's indication
    iv. Member has a genetic mutation that is resistant to the formulary preferred agents
    v. All other formulary preferred agents are not alternatives supported by NCCN Clinical Practice Guidelines for the indication

Continuation of Therapy:
Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an oncology indication (FDA-approved indications and compendial uses) when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Dosage and Administration:
The dose prescribed is within the FDA-approved dosing parameters or supported by compendia (NCCN, Micromedex DrugDex, Clinical Pharmacology) for the indication and patient specific factors (for example., age, weight or Body Surface Area (BSA), renal function, liver function, drug interactions, etc.).

Exclusions:
Coverage will not be provided for members with any of the following exclusions:
A. Member has a contraindication to the medication
B. Member is taking other medications that should be avoided with the requested drug based on the FDA-approved labeling
C. Request is for experimental / investigational use or for a clinical trial

Approval Duration and Quantity Restrictions:

Approval:
Initial Approval: 3 months
Renewal Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quanitity level limits

References:

National Comprehensive Cancer Network (NCCN). *NCCN Clinical Practice Guidelines in Oncology*. Available from: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed March 2024.