Utilization Management Policy Name: ACA Copay Waiver

Summary of Criteria:
Some generic medications/devices for preventative care are available to members at $0 cost share under non-grandfathered plans. If a healthcare provider certifies the member clinically unable to utilize the medications available at $0 cost share, then the requested alternate drug/device may be provided at $0 cost share for the member. For information and listings of preventative drugs/devices that can be obtained with $0 cost share, please visit http://www.BlueCrossNC.com/preventive.

Criteria for Approval:

1. The request is for brand name Soltamox (tamoxifen) oral solution; **AND**
    a. The patient is utilizing the requested medication for primary prevention of breast cancer because the patient is high risk; **AND**
    b. The patient does not have a prior diagnosis of breast cancer; **AND**
    c. The patient has difficulty swallowing or cannot swallow generic tamoxifen tablets; **OR**
    d. The patient has a documented intolerance or hypersensitivity to generic tamoxifen tablets; **OR**

2. The request is for Femara (letrozole); **AND**
    a. The patient is utilizing the requested medication for primary prevention of breast cancer because the patient is high risk; **AND**
    b. The patient does not have a prior diagnosis of breast cancer; **AND**
    c. The provider has certified that the patient is clinically unable to utilize the medications available at $0 cost share (anastrozole, tamoxifen, raloxifene); **OR**

3. The request is for Apretude, Descovy, or emtricitabine-tenofovir (generic Truvada); **AND**
    a. The patient's cost share is not automatically adjudicating at 0% member cost share; **AND**
    b. The patient is utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV; **AND**

4. The request is for brand name Truvada; **AND**
    a. The patient is utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV **(medical record documentation required)**; **AND**
    b. The patient had a sub-therapeutic or intolerance response (therapeutic failure) to an inactive ingredient of the generic product, but not present in the Brand **(medical record documentation required)**; **AND**
        i. The patient has a documented intolerance to an inactive ingredient of the generic product that are not found in the brand **(medical record documentation required)**; **OR**

5. The request is for one of the following agents: Atorvastatin 10-80 mg per day, Fluvastatin 20-80 mg per day, Fluvastatin ER 80 mg per day, Lovastatin ER 20-40 mg per day, Pitavastatin 1-4 mg per day, Rosuvastatin 5-40 mg per day, Simvastatin 10-40 mg per day; **AND**
    a. The requested statin is covered under the pharmacy benefit or has been previously approved by BlueCross NC; **AND**
    b. The prescriber has certified that the member is clinically unable to utilize the medications available at $0 cost share (pravastatin, lovastatin); **AND**
    c. The patient is 40-75 years of age; **AND**
    d. The patient has at least one of the following risk factors:
        i. Dyslipidemia
        ii. Diabetes
        iii. Hypertension
        iv. Smoking; **AND**
    e. The patient has a calculated 10-year risk of a cardiovascular event of 10% or greater per the American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator; **OR**

6. The request is for a contraceptive medication/device; **AND**
    a. The requested medication/device is covered under the pharmacy benefit or has been previously approved by BlueCross NC; **AND**
    b. The patient's attending provider recommends the non-preferred version of the prescribed contraceptive based on a determination of medical necessity; **OR**

7. The request is for a bowel preparation medication; **AND**
    a. The requested medication is covered under the pharmacy benefit or has been previously approved by BlueCross NC; **AND**
    b. The requested medication is not listed as available to members at $0 cost share; **AND**
    c. The provider has certified that the member is clinically unable to utilize the medications available at $0 cost share.

Duration of approval: 365 days (1 year)

References:

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf

Policy Implementation/Update Information: Criteria and treatment protocols are reviewed annually by the Blue Cross NC P&T Committee,

January 2025: Criteria change: Descovy no longer required to step through generic Truvada. Condensed Apretude, Descovy, and generic Truvada to one line. Removed Viread from policy.
September 2023: Criteria change: Updated statin criteria to include high intensity statins.
January 2023: Criteria change: Added language on Apretude coverage for PrEP. Removed medical record requirements for requests for generic Truvada.
August 2022: Criteria change: Updated language on contraceptive medication/device requirements. Added language for requests for generic Truvada.
July 2021: Criteria change: Brand Truvada requests must certify the patient is unable to take generic Truvada. Descovy added to policy. Duration of approval 365 days.
April 2021: Criteria change: Updated language on brand contraceptive medication device requirements. Brand or generic Truvada available for $0 cost share.
October 2020: Criteria change: Added letrozole to policy for breast cancer prevention.
July 2020: Criteria change: Added section for Viread, Truvada and statin requests All ACA Copay Waiver criteria combined into one policy.
September 2016: Removed language specific to contraceptive drugs/devices. Updated verbiage and website information.
August 2015: Original utilization management criteria issued.