August 1, 2018

RE: Medical Policy, Clinical UM Guidelines, and Pre-certification changes notification letter

Dear Provider:

Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Nevada (Anthem) are pleased to provide you with our updated and new medical policies. Anthem will also be implementing changes to our Clinical Utilization Management (UM) Guidelines that are adopted for Colorado/Nevada. The Clinical UM guidelines published on our website represent the clinical UM guidelines currently available to all Plans for adoption throughout our organization. Because local practice patterns, claims systems and benefit designs vary, a local Plan may choose whether or not to implement a particular clinical UM guideline. The link below can be used to confirm whether or not the local Plan has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan.

The major new policies and changes are summarized below. Please refer to the specific policy for coding, language, and rationale updates and changes that are not summarized below.

New Medical Policies effective for service dates on and after November 1, 2018

- **DRUG.00098 Lutetium Lu 177 dotatate (Lutathera®):** This document outlines the Medically Necessary and Investigational and Not Medically Necessary criteria for the use of lutetium Lu 177 dotatate (Lutathera), a therapeutic radiopharmaceutical agent for the treatment of gastroenteropancreatic neuroendocrine tumors and other indications.

Revised Medical Policies and Adopted Clinical UM Guidelines effective November 1, 2018:

- **DRUG.00050 Eculizumab (Soliris®):** This document addresses the use of eculizumab in the treatment of individuals with paroxysmal nocturnal hemoglobinuria (PNH), atypical hemolytic uremic syndrome (aHUS), generalized myasthenia gravis, and other conditions.
    - Revised Medically Necessary criteria for continuation of treatment in aHUS, adding criteria for use until an individual becomes a candidate for physician-directed cessation.
    - Added Medically Necessary criteria and a Note for resumption of eculizumab when relapse occurs following discontinuation of therapy for aHUS.

Anthem Medical Policies and Clinical UM Guidelines are developed by our national Medical Policy and Technology Assessment Committee. The Committee, which includes Anthem medical directors and representatives from practicing physician groups, meets quarterly to review current scientific data and clinical developments.

All coverage written or administered by Anthem excludes from coverage, services or supplies that are investigational and/or not medically necessary. A member's claim may not be eligible for payment if it was determined not to meet medical necessity criteria set in Anthem's medical policies. Review procedures have been refined to facilitate claim investigation.

Anthem's Medical Policies and Clinical UM Guidelines are available online:

The complete list of our Medical Policies and Clinical UM Guidelines may be accessed on Anthem's Web site at **anthem.com**. Select **Providers**, and **Providers Overview**. Select **Find Resources for Your State** and pick **Nevada**. On the **Provider Home** page, from the **Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements tout** (*2nd blue box on the left side of page*), select **enter**. Select the link titled "**Medical Policies and Clinical UM Guidelines (for Local Plan Members)**". Choose **Continue**, then select the either the **Medical Policies** or the **UM Guidelines** tab.

To view the list of specific clinical UM guidelines adopted by Nevada, navigate to the Disclaimer page by following the instructions above; scroll to the bottom of the page. Above the "Continue" button, choose the link titled "**Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Nevada**."

Sincerely,

Allen Marino, M.D.
Medical Director
Anthem Blue Cross and Blue Shield

Attachment A – Revised Medical Policies and Clinical Guidelines

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
DME.00035	Electric Tumor Treatment Field (TTF)	• Medical policy archived 06/28/2018. Recategorized to CG-DME-44.
DRUG.00036	Cetuximab (Erbitux®)	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-67.
DRUG.00041	Rituximab (Rituxan®) for Non-Oncologic Indications	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-94.
DRUG.00046	Ipilimumab (Yervoy®)	• Added the treatment of intermediate- or poor-risk, advanced renal cell carcinoma (RCC) in combination with nivolumab as Medically Necessary when criteria are met. • Clarified Medically Necessary criteria addressing treatment of melanoma to include both cutaneous and uveal. • Removed RCC from Investigational and Not Medically Necessary list. • Reformatted Medically Necessary criteria.
DRUG.00047	Brentuximab Vedotin (Adcetris®)	• Revised Medically Necessary criteria addressing Hodgkin lymphoma. • Added previously untreated stage III or IV classical Hodgkin lymphoma, in combination with chemotherapy as Medically Necessary. • Expanded Medically Necessary criteria to include therapy as a single agent for relapsed or refractory Hodgkin lymphoma in a single line of therapy.
DRUG.00049	Belatacept (Nulojix®)	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-95.
DRUG.00053	Carfilzomib (Kyprolis®)	• Added primary treatment of multiple myeloma as Medically Necessary when criteria are met. • Reformatted Medically Necessary criteria.
DRUG.00056	Ado-trastuzumab emtansine (Kadcyla®)	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-96.
DRUG.00071	Pembrolizumab (Keytruda®)	• Clarified Medically Necessary criteria addressing treatment of melanoma to include both cutaneous and uveal. • Revised Medically Necessary criteria for nonsquamous NSCLC to include combination therapy with a platinum agent.
DRUG.00073	Rilonacept (Arcalyst®)	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-97.
DRUG.00075	Nivolumab (Opdivo®)	• Clarified Medically Necessary criteria addressing treatment of melanoma to include both cutaneous and uveal. • Added the treatment of intermediate- or poor-risk, advanced renal cell carcinoma (RCC) in combination with ipilimumab as Medically Necessary when criteria are met.
DRUG.00076	Blinatumomab (Blincyto®)	• Added minimal residual disease greater than or equal to 0.1%, following a first or second complete response to induction therapy to Medically Necessary criteria.
DRUG.00079	Bendamustine Hydrochloride	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-98.
DRUG.00083	Elotuzumab (Empliciti™)	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-99.
DRUG.00084	Interferon gamma-1b (Actimmune®)	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-100.
DRUG.00085	Ixabepilone (Ixempra®)	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-101.
DRUG.00097	Olaratumab (Lartruvo™)	• Medical policy archived 06/28/2018. Recategorized to CG-DRUG-

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
		102.
DRUG.00104	Nusinersen (SPINRAZA®)	• Revised title. Previous title: Nusinersen (SPINRAZA™) • Revised Note addressing Dosing.
DRUG.00111	Monoclonal Antibodies to Interleukin-23	• Revised title. Previous title: Guselkumab (Tremfya™) • Expanded scope of policy to include both FDA-approved anti-interleukin-23 monoclonal antibodies developed for use in adults for the treatment and maintenance of moderate to severe plaque psoriasis. • Added Tildrakizumab-asmn (Ilumya™) to Medically Necessary, Not Medically Necessary, and Investigational and Not Medically Necessary statements.
GENE.00012	Preconception or Prenatal Genetic Testing of a Parent or Prospective Parent	• Removed the genetic counseling requirement for cystic fibrosis and spinal muscle atrophy. • Added a note stating "Genetic counseling should be a component of a decision to perform genetic testing" in position statement.
GENE.00026	Cell-Free Fetal DNA-Based Prenatal Testing	• Removed the genetic counseling requirement for fetal aneuploidy and fetal sex determination. • Added a note stating "Genetic counseling should be a component of a decision to perform genetic testing" in position statement.
MED.00026	Hyperthermia for Cancer Therapy	• Medical policy archived 06/28/2018. Recategorized to CG-MED-72.
SURG.00001	Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty	• Medical policy archived 06/28/2018. Recategorized to CG-SURG-76.
SURG.00009	Refractive Surgery	• Medical policy archived 06/28/2018. Recategorized to CG-SURG-77.
SURG.00026	Deep Brain, Cortical, and Cerebellar Stimulation	• Removed Medically Necessary criteria requiring failure of prior vagal nerve stimulation (VNS) treatment before cortical stimulation with the RNS System.
SURG.00032	Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention	• Removed brand name from Medically Necessary criteria for transcatheter closure of patent foramen ovale.
SURG.00065	Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies	• Medical policy archived 06/28/2018. Recategorized to CG-SURG-78.
SURG.00068	Implantable Infusion Pumps	• Medical policy archived 06/28/2018. Recategorized to CG-SURG-79.
RAD.00011	Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Treating Primary or Metastatic Liver Tumors	• Medical policy archived 06/28/2018. Recategorized to CG-SURG-80.
THER-RAD.00002	Proton Beam Radiation Therapy	• Medical policy archived 11/01/2018.
CG-ADMIN-02	Clinically Equivalent Cost Effective Services – Targeted Immune Modulators	• Added new FDA-approved drug, tildrakizumab-asmn (Ilumya™), for adult plaque psoriasis.

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
CG-DRUG-05	Recombinant Erythropoietin Products	• Added new section addressing Clinically Equivalent Cost Effective Agents (CECEA).
CG-DRUG-09	Immune Globulin (Ig) Therapy	• Clarified Not Medically Necessary statement to specifically address pediatric autoimmune neuropsychiatric disorder associated with group A streptococci (PANDAS). • Updated Clinically Equivalent Cost Effective Agents (CECEA) section.
CG-DRUG-16	White Blood Cell Growth Factors	• Added new section addressing Clinically Equivalent Cost Effective Agents (CECEA).
CG-DRUG-25	Intravenous versus Oral Drug Administration in the Outpatient and Home Setting	• Added Delafloxacin to the list of examples of bioequivalent flouroquinolone antibiotics. • Moved examples of bio-equivalent intravenous and oral medications from the clinical indications section to the discussion section.
CG-DRUG-50	Paclitaxel, protein bound (Abraxane®)	• Revised Medically Necessary criteria for recurrent, metastatic or high-risk uterine/endometrial cancer. • Added the treatment of solid tumors as Medically Necessary when criteria are met. • Clarified Medically Necessary criteria for Breast Cancer, NSCLC, and Ovarian Cancer.
CG-DRUG-62	Fulvestrant (FASLODEX®)	• Added combination use with abemaciclib as Medically Necessary for breast cancer when criteria are met.
CG-DRUG-73	Denosumab (Prolia®, Xgeva®)	• Clarified Medically Necessary statement for Xgeva when used for the prevention of skeletal-related events. • Reformatted Medically Necessary criteria.
CG-DRUG-78	Antihemophilic Factors and Clotting Factors	• Expanded use of Vonvendi in von Willebrand disease to include peri-procedural management for surgical, invasive or interventional radiology procedures. • Added new section addressing Clinically Equivalent Cost Effective Agents (CECEA).