BlueCross BlueShield of Kansas
An Independent Licensee of the Blue Cross and Blue Shield Association.

ACA Prevention Copay Waiver Criteria – Individual Marketplace, Commercial

- **BCBSKS will review Prior Authorization requests**
  Prior Authorization Form:
  https://www.bcbsks.com/CustomerService/Forms/pdf/PriorAuth-6324KS-COWA.pdf

  Link to Drug List (Formulary):
  https://www.bcbsks.com/drugs/

CLINICAL RATIONALE
The Affordable Care Act (ACA) requires a member-friendly mechanism for waiving the cost share for an alternative recommended product deemed medically necessary by the provider when a health care provider considers the $0 covered product is inappropriate for an individual. Prime Therapeutics offers a standard coverage exception/cost share waiver policy that is applied across all ACA categories.

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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

POLICIES **Page**

Human Immunodeficiency Virus (HIV) Infection: Pre-exposure Prophylaxis (PrEP) ACA Prevention Copay Waiver Criteria

OBJECTIVE
The intent of the ACA Prevention Copay Waiver Criteria is to help ensure the copay waiver, when applicable based on the member's benefit, is applied to the appropriate population as described by the United States Preventative Services Task Force (USPSTF).

CRITERIA FOR APPROVAL
The requested HIV infection pre-exposure prophylaxis (PrEP) agent will be approved when ALL of the following are met:

1. The requested PrEP agent is covered under the pharmacy benefit or has been approved through the coverage exception process
   AND
2. The prescriber has provided information stating that the requested PrEP agent is medically necessary compared to other available PrEP agents
   AND
3. ONE of the following:
   a. The requested PrEP agent is ONE of the following:
      i. Tenofovir disoproxil fumarate and emtricitabine combination ingredient agent
         OR
      ii. Tenofovir disoproxil fumarate single ingredient agent
         OR
      iii. Tenofovir alafenamide and emtricitabine combination ingredient agent
   OR
   b. The prescriber has provided information stating that a tenofovir disoproxil fumarate and emtricitabine combination ingredient agent, tenofovir disoproxil fumarate single ingredient agent, or tenofovir alafenamide and emtricitabine combination ingredient agent is contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient
   AND
4. The patient is at high risk of HIV infection
   AND
5. The patient has recently tested negative for HIV

Length of Approval: 12 months

Statin ACA Prevention Copay Waiver Criteria

OBJECTIVE
The intent of the ACA Prevention Copay Waiver Criteria is to help ensure the copay waiver, when applicable based on the member's benefit, is applied to the appropriate population as described by the United States Preventative Services Task Force (USPSTF). The USPSTF recommendation requires the calculation of Atherosclerotic Cardiovascular Disease (ASCVD) risk. The calculation requires inputting the patient's gender, age, race, high density lipoprotein (HDL) cholesterol, total cholesterol, blood pressure, whether the patient has diabetes, whether the patient is under treatment for hypertension, and whether the patient is an active smoker.[1]

1. American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator. Available at: https://tools.acc.org/ASCVD-Risk-Estimator/ Accessed on 3/1/2017.

CRITERIA FOR APPROVAL

The requested statin will be approved when ALL of the following are met:

1. The requested agent is a generic statin (MSC=Y) unless a generic statin is not available for the requested agent
   AND
2. The requested statin is covered under the pharmacy benefit or has been approved through the coverage exception process
   AND
3. The requested statin is not covered on a $0 Affordable Care Act (ACA) list
   AND
4. The prescriber has provided information stating that the requested statin is medically necessary
   AND
5. The requested agent is for use in ONE of the following low to moderate daily statin regimen (with up to the highest dosage strength as noted):
   a. Atorvastatin 10-20 mg per day (20 mg tablet)
   b. Fluvastatin 20-80 mg per day (40 mg capsule)
   c. Fluvastatin ER 80 mg per day (80 mg tablet)
   d. Lovastatin 20-40 mg per day (40 mg tablet)
   e. Lovastatin ER 20-40 mg per day (40 mg tablet)
   f. Pitavastatin 1-4 mg per day (4 mg tablet)
   g. Pravastatin 10-80 mg per day (80 mg tablet)
   h. Rosuvastatin 5-10 mg per day (10 mg tablet)
   i. Simvastatin 10-40 mg per day (40 mg tablet, 40 mg/5 mL suspension)
   AND
6. The requested statin is for use in the primary prevention of cardiovascular disease (CVD)
   AND
7. The patient is 40-75 years of age (inclusive)
   AND
8. The patient has at least one of the following risk factors:
   a. Dyslipidemia
   b. Diabetes
   c. Hypertension
   d. Smoking
   AND
9. 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

Length of Approval: 12 months

Effective: July 1, 2020
Prior Revisions: October 1, 2017, January 1, 2018, December 1, 2018