Medical Policy

An Independent licensee of the
Blue Cross Blue Shield Association

Title: ACA Prevention Copay Waiver Criteria – Individual Marketplace, Commercial

Professional / Institutional
Original Effective Date: October 1, 2017
Latest Review Date: June 15, 2026
Current Effective Date: June 15, 2026

State and Federal mandates and health plan member contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. To verify a member's benefits, contact Blue Cross and Blue Shield of Kansas Customer Service.

The BCBSKS Medical Policies contained herein are for informational purposes and apply only to members who have health insurance through BCBSKS or who are covered by a self-insured group plan administered by BCBSKS. Medical Policy for FEP members is subject to FEP medical policy which may differ from BCBSKS Medical Policy.

The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents of Blue Cross and Blue Shield of Kansas and are solely responsible for diagnosis, treatment and medical advice.

If your patient is covered under a different Blue Cross and Blue Shield plan, please refer to the Medical Policies of that plan.

CLINICAL RATIONALE

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. 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 https://mchb.hrsa.gov/programs-impact/programs/preventive-guidelines-screenings-women-children-youth https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

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See package insert for FDA preshttps://dailymed.nlm.nih.gov/dailymed/index.cfm

CODING

The following codes for treatment and procedures applicable to this policy are included below for informational purposes. This may not be a comprehensive list of procedure codes applicable to this policy.

Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

The code(s) listed below are medically necessary ONLY if the procedure is performed according to the "Policy" section of this document.

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
Breast Cancer Primary Prevention Agent ACA 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 breast cancer primary prevention agent will be approved when ALL of the following are met: 1. The requested breast cancer primary prevention agent is covered under the pharmacy benefit or has been approved through the coverage exception process **AND** 2. There is support that the requested breast cancer primary prevention agent is medically necessary **AND** 3. The requested agent is tamoxifen, raloxifene, or an aromatase inhibitor (anastrozole, exemestane, letrozole) **AND** 4. The patient is 35 years of age or over **AND** 5. The agent is requested for the primary prevention of breast cancer **AND** 6. ONE of the following: A. The plan has not implemented a sex requirement **OR** B. The plan has implemented a sex requirement AND ONE of the following: 1. The patient's sex is female **OR** 2. The requested agent is medically appropriate for the patient's sex **Length of Approval:** 12 months

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Module	Clinical Criteria for Approval
Contraceptives 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 Health Resources & Services Administration (HRSA) in support of Women's Preventive Care. **CRITERIA FOR APPROVAL** The requested contraceptive agent will be approved when ALL of the following are met: 1. The requested contraceptive agent is covered under the pharmacy benefit or has been approved through the coverage exception process **AND** 2. The requested agent is being used for contraception **AND** 3. There is support that the requested contraceptive agent is medically necessary 1. **Length of Approval:** 12 months
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 requested agent is being used for PrEP **AND** 3. There is support that the requested PrEP agent is medically necessary **AND** 4. The requested PrEP agent is ONE of the following: A. Tenofovir disoproxil fumarate and emtricitabine combination ingredient agent **OR** B. Tenofovir alafenamide and emtricitabine combination ingredient agent **AND** C. Cabotegravir **OR** D. Yeztugo (lenacapavir) **AND** 5. The patient has increased risk for HIV infection **AND** 6. 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 sex, 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.

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<table>
<tr><th>Module</th><th>Clinical Criteria for Approval</th></tr>
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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. There is support that the requested statin is medically necessary **AND**
4. The requested statin is for use in the primary prevention of cardiovascular disease (CVD) **AND**
5. The patient is 40-75 years of age (inclusive) **AND**
6. The patient has at least one of the following risk factors:
   A. Dyslipidemia
   B. Diabetes
   C. Hypertension
   D. Smoking **AND**
7. 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

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Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

<table>
<tr><th colspan="2">REVISIONS</th></tr>
<tr><td>10-01-2017</td><td>Policy added to the bcbsks.com web site.</td></tr>
<tr><td>12-13-2022</td><td>Policy reviewed and maintained by Prime Therapeutics with no revisions</td></tr>
<tr><td>01-05-2024</td><td>Policy reviewed and maintained by Prime Therapeutics with no revisions</td></tr>
<tr><td>07-01-2024</td><td>Contraceptives added to policy</td></tr>
<tr><td>11-20-2024</td><td>Policy reviewed and updated; policy statement unchanged. Policy maintained by Prime Therapeutics.</td></tr>
<tr><td>Posted:
05-14-2026
Effective:
06-15-2026</td><td>Policy Updates:
• Resources added to Clinical Rationale
• "Client Summary- Prior Authorization" title removed since there was nothing in that section
• Reference moved to the bottom of the document
• Cabotegravir and Yeztugo were added to the PrEP agents
Policy reviewed and maintained by Prime Therapeutics.</td></tr>
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REFERENCES

Number	Reference
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 7/27/2023.

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