DRUG DETERMINATION POLICY

Title: DDP-08 Site of Care for Administration of Parenteral Specialty Drugs

Effective Date: 07/01/2019

Physicians Health Plan
PHP Insurance Company
PHP Service Company

Important Information - Please Read Before Using This Policy

The following policy applies to health benefit plans administered by PHP and may not be covered by all PHP plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Benefit determinations for individual requests require consideration of:

1. The terms of the applicable benefit document in effect on the date of service.
2. Any applicable laws and regulations.
3. Any relevant collateral source materials including coverage policies.
4. The specific facts of the particular situation.

Contact PHP Customer Service to discuss plan benefits more specifically.

1.0 Policy:

This policy describes the determination process for coverage of specific specialty drugs at an outpatient facility that bills with a facility fee. Drugs included in this policy must also meet medication prior approval criteria for coverage, regardless of the site of care for the service received.

This policy does not guarantee or approve benefits. Coverage depends on the specific benefit plan. Drug Determination Policies are not recommendations for treatment and should not be used as treatment guidelines.

2.0 Background or Purpose:

The site of care policy directs members to the most cost-effective, clinically appropriate location for administration of select parenteral specialty drugs listed in this policy.

3.0 Clinical Determination Guidelines:

Document the following with chart notes

A. The drugs listed in the table below:
    1. Must be administered at a non-facility setting, such as a provider's office, through home infusion services, or at an ambulatory infusion center.
        a. May be administered at an outpatient facility for the first dose.

B. Exception criteria for approval of hospital outpatient level of care:
    1. Prior infusion adverse reactions.
        a. Previous experience of a severe adverse event following infusion requiring hospitalization (e.g., anaphylaxis, seizure, thromboembolism, renal failure).
        b. Continuing experience of adverse events that cannot be mitigated by pre-medications.
    2. Geographical access.

a. Home infusion providers unable to access member and the nearest office-based provider who can provide the service exceeds the travel distance to the currently servicing hospital outpatient center by 20 miles.

b. Home infusion provider has deemed that the member's home environment is not suitable for home infusion therapy and the nearest office-based provider who can provide the service exceeds the travel distance to the currently servicing hospital outpatient center by 20 miles.

3. Member out-of-pocket expense.

a. Benefit plan design where financial impact to member is greater than an outpatient infusion facility .

b. SHS ASO products: groups L0001269, L0000264.

4.0 Coding:

The policy applies to the codes below:

HCPCS Code	Brand Name	Generic Name	HCPCS Units (mgs/unit)
J0490	Benlysta	belimumab	10mg
J0897	Xgeva, Prolia	denosumab	500mg
J1459	Privigen	immune globulin	500mg
J1460	GamaSTAN SD	immune globulin	500mg
J1555	Cuvitru	immune globulin	500mg
J1556	Bivigam	immune globulin	500mg
J1557	Gammaplex	immune globulin	500mg
J1559	Hizentra	immune globulin	500mg
J1560	GamaSTAN SD, over 10 mL	immune globulin	500mg
J1561	Gamunex-C, Gammaked	immune globulin	500mg
J1562	Vivaglobin	immune globulin	500mg
J1566	Carimune	immune globulin	500mg
J1568	Octagam	immune globulin	500mg
J2569	Gammagard	immune globulin	500mg
J1572	Flebogamma	immune globulin	500mg
J1575	HyQvia	immune globulin	500mg
J1599	Immune globulin, NOS	immune globulin	500mg
J1602	Simponi Aria	golimumab	1mg
J1745	Remicade	infliximab	10mg
J2357	Xolair	omalizumab	5mg
J3357	Stelara	ustekinumab	1mg
J3380	Entyvio	vedolizumab	1mg
Q5103	Inflectra	infliximab	10mg
Q5104	Renflexis	infliximab	10mg

5.0 References, Citations & Resources:

None.

6.0 Associated Documents:

None.

7.0 Revision History:

Original Effective Date: 7/1/2019

Last Approval Date: 06/12/2019

Next Review Date: 06/12/2020

Revision Date	Reason for Revision
2/19	Moved to new format;
4/19	Brought to P & T Workgroup, revisions made by J Wahawisan