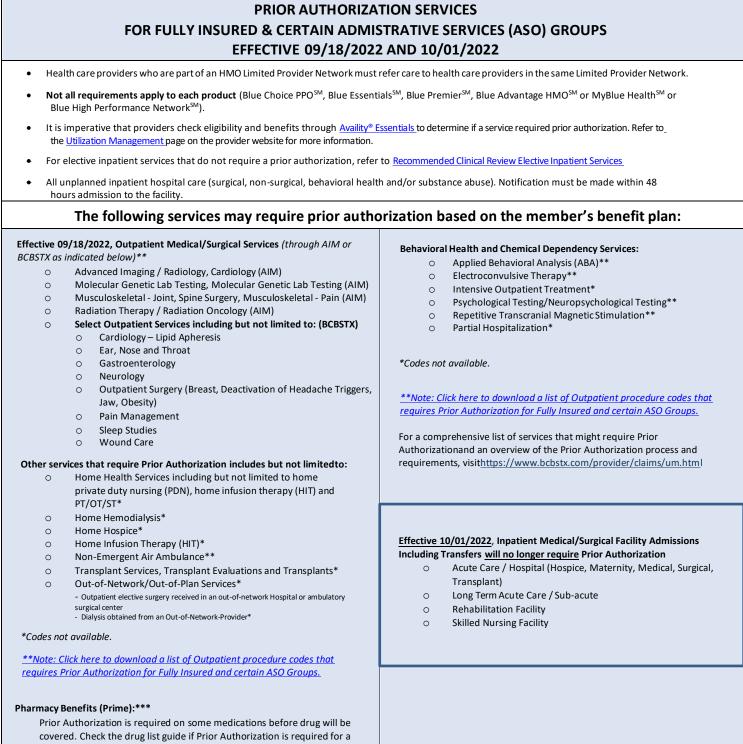


Posted 09/2022



covered. Check the drug list guide if Prior Authorization is required for a specific drug.

***Note: Click here to view Drug Lists and determine if the drug requires Prior Authorization under Pharmacy Benefits for Fully Insured (FI) and certain ASO Groups.

Specialty Pharmacy Medications that are covered by Medical Benefits**

- Infusion Site of Care *medical necessity review required for therapy and for place of infusion.*
- Medical Oncology & Supportive Care (through AIM) medical necessity review required for oncology drugs that are supported by an oncology diagnosis
- Provider Administered Drug Therapies medical necessity review required for therapy only

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PRIOR AUTHORIZATION SCREENING CRITERIA FOR FULLY INSURED CERTAIN ADMISTRATIVE SERVICES (ASO) GROUPS EFFECTIVE 09/18/2022

MEDICAL/SURGICAL SCREENING CRITERIA	BEHAVIORAL HEALTH SCREENING CRITERIA
MCG Care Guidelines (MCG)	MCG Care Guidelines (MCG)
 BCBSTX Medical Policies (MP) 	 BCBSTX Medical Policies (MP)
 American Society of Addiction Medicine (ASAM) Criteria 	 Texas Department of Insurance (DOI) Standards for Reasonable Cost Control
 Texas Department of Insurance Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency (CD) Treatment Centers for 	and Utilization Review for Chemical Dependency Treatment Centers
CD service provided in Texas	Magellan Health (vendor solution for certain plans):
 AIM Specialty Health (AIM) (vendor solution): AIM Evidence-based 	Magellan Healthcare Guidelines
Guidelines	American Society of Addiction Medicine (ASAM) Criteria

PHARMACY SCREENING CRITERIA

For the Provider Administered Drug Therapy Reviews, the screening criteria used are contained within BCBSTX Medical Policies which include the statement:

Medical policies are a set of written guidelines that support current standards of practice. They are based on current peer- reviewed scientific literature. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and nationally recognized authoritative references. These references include, but are not limited to: MCG care guidelines, DrugDex (IIb level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines and CMS coverage policy.

Due to the above, Provider Administered Drug Therapy Reviews also leverages information contained within the package insert, NCCN, DrugDex, etc. in addition to the medical policies themselves.

<u>Click here to review clinical criteria applied for drugs covered by Pharmacy Benefits.</u>

*Applicable Administrative Services Only Accounts

- BCS - GANNETT EXECUTIVES - SUPPLEMENTAL PLANS - GROUP # 193211

- BCS - TEGNA, INC - SUPPLEMENTAL PLANS - GROUP # 193219

- SPEAKING ROCK ENTERTAINMENT CENTER - GROUP # 290491

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