MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy

Sublingual Immunotherapy with Allergen-specific Extracts (SLIT)

Table of Contents

Policy Number: 681

BCBSA Reference Number: None

Related Policies

- Quality Care Dosing guidelines apply to the following medications and can be found in Medical Policy #**621A**

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy only **(ALL SLIT PRODUCTS ARE EXCLUDED FROM MAIL ORDER)** for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Prior Authorization Information

☒ **Prior Authorization** ☐ **Step Therapy** ☒ **Quality Care Dosing**		**Pharmacy Operations:** Tel: 1-800-366-7778 Fax: 1-800-583-6289 Policy last updated **3/2024**
Pharmacy (Rx) or Medical (MED) benefit coverage	☒ **Rx** ☐ **MED**	**To request for coverage:** Physicians may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below. **Blue Cross Blue Shield of Massachusetts** **Pharmacy Operations Department** 25 Technology Place Hingham, MA 02043 **Individual Consideration:** Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration
Policy applies to Commercial Members: • Managed Care (HMO and POS), • PPO and Indemnity • MEDEX with Rx plan • Managed Major Medical with Custom BCBSMA Formulary • Comprehensive Managed Major Medical with Custom BCBSMA Formulary • Managed Blue for Seniors with Custom BCBSMA Formulary		

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

Drug	Formulary Information Standard Formulary Status
GRASTEK ® (timothy grass pollen allergen)	PA Required
ODACTRA ™ (dermatophagoides pteronyssinus/dermatophagoides farina)	PA Required
ORALAIR ® (anthoxanthum odoratum pollen, dactylis glomerata pollen, lolium perenne pollen, phelum pratense pollen, and poa pratensis pollen)	PA Required
RAGWITEK ™ (ambrosia artemisiifolia pollen)	PA Required

We may cover at retail pharmacy only Grastek ® when **all** of the following criteria are met[1]:

- Being used as immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis caused by Timothy grass or cross-reactive grass pollens, **AND**
- For use in persons 5 through 65 years of age, **AND**
- Prescribed by a board certified or board eligible allergist or board certified or board eligible Otolaryngologists **OR** Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies.

  *Approvals for treatment when provided are limited to start the time period needed before the expected onset of the allergy-inducing pollen season and continued throughout the pollen season.

We may cover at retail pharmacy only **Odactra** ™ when **all** of the following criteria are met:

- Being used as immunotherapy for treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, **AND**

- Prescribed by a board certified or board eligible allergist or board certified or board eligible Otolaryngologists **OR** Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies, **AND**
- For use in persons 12 through 65 years of age.

*Approvals for treatment when provided are limited to start the time period needed before the expected onset of the allergy-inducing pollen season and continued throughout the pollen season.

We may cover at retail pharmacy only Oralair ® when **all** of the following criteria are met[1]:
- Being used as immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis, **AND**
- Prescribed by a board certified or board eligible allergist or board certified or board eligible Otolaryngologists **OR** Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies, **AND**
- For use in persons 5 through 65 years of age.

*Approvals for treatment when provided are limited to start the time period needed before the expected onset of the allergy-inducing pollen season and continued throughout the pollen season.

We may cover at retail pharmacy only Ragwitek ™ when **all** of the following criteria are met[1]:
- Being used as immunotherapy for treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, **AND**
- Prescribed by a board certified or board eligible allergist or board certified or board eligible Otolaryngologists **OR** Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies, **AND**
- For use in persons five (5) through 65 years of age.

*Approvals for treatment when provided are limited to start the time period needed before the expected onset of the allergy-inducing pollen season and continued throughout the pollen season.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

We do not cover the above drugs for other conditions not listed above.

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code 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 as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts

Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Policy History

Date	Action
3/2024	Updated to change age on Odactra ™ and Oralair.
7/2023	Reformatted Policy.
7/2022	Clarified coding between specialist and a confirmed test.
7/2021	Updated to increase Ragwitek's age indication with FDA update.
4/2020	Clarified prescribing specialists for all SLITs.
3/2018	Updated to include Odactra™
6/2017	Updated address for Pharmacy Operations.
4/2017	Added criteria for Otolaryngologists.
8/2015	Updated approved ages for Oralair®
10/2014	Implemented New policy.

References

1. GRASTEK® [package insert]. Whitehouse Station, NJ: Merck & CO., Inc.: 2014.
2. ORALAIR® [package insert]. St-Laurent,Quebec: Paladin Labs., Inc.: 2014.
3. RAGWITEK™ [package insert]. Whitehouse Station, NJ: Merck & CO., Inc.: 2014.
4. ODACTRA ™ [package insert]. Swindon, Wiltshire, SN5 8RU UK: Catalent Pharma Solutions Limited: Jan 2018.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf