Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs

MassHealth Adjudicated Payment Amount per Discharge and Adjudicated Payment per Episode Carve Out Drugs

Effective: April 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐

Applies to:

Public Plans Products

☒ Tufts Health Together – MassHealth Drug Utilization Review Program; Fax 877-208-7428

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

All Prior Authorization requests for Adjudicated Payment Amount per Discharge (APAD) and Adjudicated Payment per Episode of Care (APEC) carve-out drugs (see list below) must be submitted to the MassHealth Drug Utilization Review (DUR) program for approval before administration, see fax number above.

Overview

Tufts Health Together–MassHealth MCO Plan and Accountable Care Partnership Plans, in conjunction with the other Medicaid managed care organizations (MCOs) in the Commonwealth, follow MassHealth's Unified Formulary for all gene and cell therapy medical benefit coverage.

Therapies included in this policy require prior authorization on the medical benefit with coverage criteria that mirrors the MassHealth Unified Formulary. MassHealth maintains lists of APAD and APEC carve- out drugs. Currently, these lists are comprised of one- time infused cell and gene therapies. Per MassHealth MCE Bulletin 125, effective April 1, 2025, MassHealth will review and management these drugs through the MassHealth DUR Program.

Clinical Guideline Coverage Criteria

MassHealth may authorize coverage of a therapy listed in the table below for Members when all of the MassHealth Drug List coverage criteria is met. The MassHealth clinical coverage criteria may be accessed here: (https://mhdl.pharmacy.services.conduent.com/MHDL/).

Drug	HCPCS code
Abecma	Q2055
Amtagvi	J3490
Beqvez	J1414
Breyanzi	Q2054
Carvykti	Q2056
Casgevy	J3392
Elevidys	J1413
Hemgenix	J1411
Kymriah	Q2042
Lenmeldy	J3490

Drug	HCPCS code
Luxturna	J3398
Lyfgenia	J3394
Omisigre	J3590
Roctavian	J1412
Skysona	J3590
Tecartus	Q2053
Tecelra	Q2057
Yescarta	Q2041
Zolgensma	J3399
Zynteglo	J3393

Limitations

- None

Codes

The following code(s) require prior authorization:

- See table in Clinical Guideline Coverage Criteria section

References

1. Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. (2025, March). *Managed Care Entity Bulletin 125: Cell and Gene Therapy Adjudicated Payment Amount per Discharge and Adjudicated Payment per Episode of Care Carve-Out*. 2025 MassHealth Provider Bulletins. https://www.mass.gov/doc/managed-care-entity-bulletin-125-cell-and-gene-therapy-adjudicated-payment-amount-per-discharge-and-adjudicated-payment-per-episode-of-care-carve-out-0/download
2. *MassHealth Acute Hospital Carve-Out Drugs List*. MassHealth Drug List- Health and Human Services. (2025, February). https://mhdl.pharmacy.services.conduent.com/MHDL/pubdownloadpdfwelcome.do?docId=447&fileType=PDF

Approval And Revision History

March 19, 2025: Reviewed by the Medical Policy Approval Committee (MPAC), effective April 1, 2025

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and

benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.