

Medical Policy



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

Professional / Institutional
Original Effective Date: October 1, 2017
Latest Review Date: November 20, 2024
Current Effective Date: August 1, 2024

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	<p>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.</p> <p>https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf</p>
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See package insert for FDA pres<https://dailymed.nlm.nih.gov/dailymed/index.cfm>

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.

CLIENT SUMMARY – PRIOR AUTHORIZATION

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
Breast Cancer Primary Prevention Agent ACA Copay Waiver Criteria	<p>OBJECTIVE</p> <p>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).</p> <p>CRITERIA FOR APPROVAL</p> <p>The requested breast cancer primary prevention agent will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> A. The plan has not implemented a sex requirement OR B. The plan has implemented a sex requirement AND ONE of the following: <ol style="list-style-type: none"> 1. The patient’s sex is female OR 2. The requested agent is medically appropriate for the patient’s sex <p>Length of Approval: 12 months</p>
Contraceptives ACA Prevention Copay Waiver Criteria	<p>OBJECTIVE</p> <p>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</p>

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	<p>applied to the appropriate population as described by Health Resources & Services Administration (HRSA) in support of Women's Preventive Care.</p> <p>CRITERIA FOR APPROVAL</p> <p>The requested contraceptive agent will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 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 <p>1. Length of Approval: 12 months</p>
<p>Human Immunodeficiency Virus (HIV) Infection: Pre-exposure Prophylaxis (PrEP) ACA Prevention Copay Waiver Criteria</p>	<p>OBJECTIVE</p> <p>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).</p> <p>CRITERIA FOR APPROVAL</p> <p>The requested HIV infection pre-exposure prophylaxis (PrEP) agent will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> A. Tenofovir disoproxil fumarate and emtricitabine combination ingredient agent OR B. Tenofovir alafenamide and emtricitabine combination ingredient agent AND 5. The patient has increased risk for HIV infection AND 6. The patient has recently tested negative for HIV <p>Length of Approval: 12 months</p>
<p>Statin ACA Prevention Copay Waiver Criteria</p>	<p>OBJECTIVE</p> <p>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</p>

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	<p>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.</p> <p>CRITERIA FOR APPROVAL</p> <p>The requested statin will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 <p>Length of Approval: 12 months</p>

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.

REVISIONS	
10-01-2017	Policy added to the bcbsks.com web site.
12-13-2022	Policy reviewed and maintained by Prime Therapeutics with no revisions
01-05-2024	Policy reviewed and maintained by Prime Therapeutics with no revisions
07-01-2024	Contraceptives added to policy
11-20-2024	Policy reviewed and updated; policy statement unchanged. Policy maintained by Prime Therapeutics.