Amerigroup
An Anthem Company

Provider update

Medical drug benefit *Clinical Criteria* updates

On November 15, 2019, and February 21, 2020, the Pharmacy and Therapeutics (P&T) Committee approved the following *Clinical Criteria* applicable to the **medical drug benefit** for Amerigroup. These policies were developed, revised or reviewed to support clinical coding edits.

Visit ***Clinical Criteria*** to search for specific policies. For questions or additional information, use this **email**.

Please see the explanation/definition for each category of Clinical Criteria below:

- New: newly published criteria
- Revised: addition or removal of medical necessity requirements, new document number
- Annual review: minor wording and formatting updates, new document number
- Updates marked with an asterisk (*): criteria may be perceived as more restrictive

Please share this notice with other members of your practice and office staff.

Please note: The clinical criteria listed below applies only to the medical drug benefits contained within the member's medical plan. This does not apply to pharmacy services.

Effective date	Document number	*Clinical Criteria* title	New, revised, annual review
06/01/2020	ING-CC-0002*	Colony Stimulating Factor Agents	Revised
06/01/2020	ING-CC-0089	Mozobil (plerixafor)	Revised
06/01/2020	ING-CC-0124	Keytruda (pembrolizumab)	Revised
06/01/2020	ING-CC-0125*	Opdivo (nivolumab)	Revised
06/01/2020	ING-CC-0119*	Yervoy (ipilimumab)	Revised
06/01/2020	ING-CC-0099*	Abraxane (paclitaxel, protein bound)	Revised
06/01/2020	ING-CC-0093	Docetaxel (Taxotere)	Revised
06/01/2020	ING-CC-0094*	Alimta (pemetrexed disodium)	Revised
06/01/2020	ING-CC-0130	Imfinzi (durvalumab)	Revised
06/01/2020	ING-CC-0088*	Elzonris (tagraxofusp-erzs)	Revised
06/01/2020	ING-CC-0118*	Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Zevalin)	Revised
06/01/2020	ING-CC-0112*	Xofigo (Radium Ra 223 Dichloride)	Revised

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

https://providers.amerigroup.com/TX

Effective date	Document number	*Clinical Criteria* title	New, revised, annual review
06/01/2020	ING-CC-0123*	Cyramza (ramucirumab)	Revised
06/01/2020	ING-CC-0131	Besponsa (inotuzumab ozogamicin)	Revised
06/01/2020	ING-CC-0121	Gazyva (obinutuzumab)	Revised
06/01/2020	ING-CC-0109*	Zaltrap (ziv-aflibercept)	Revised
06/01/2020	ING-CC-0135*	Melanoma Vaccines	Revised
06/01/2020	ING-CC-0096	Asparagine Specific Enzymes	Revised
06/01/2020	ING-CC-0120	Kyprolis (carfilzomib)	Revised
06/01/2020	ING-CC-0085	Actimmune (interferon gamma-1b)	Revised
06/01/2020	ING-CC-0113	Sylvant (siltuximab)	Revised
06/01/2020	ING-CC-0129	Bavencio (avelumab)	Revised
06/01/2020	ING-CC-0090	Ixempra (ixabepilone)	Revised
06/01/2020	ING-CC-0110	Perjeta (pertuzumab)	Revised
06/01/2020	ING-CC-0108	Halaven (eribulin)	Revised
06/01/2020	ING-CC-0033*	Xolair (omalizumab)	Revised
06/01/2020	ING-CC-0043*	Monoclonal Antibodies to Interleukin-5	Revised
06/01/2020	ING-CC-0072	Selective Vascular Endothelial Growth Factor (VEGF) Antagonists	Revised
06/01/2020	ING-CC-0062*	Tumor Necrosis Factor Antagonists	Revised
06/01/2020	ING-CC-0049*	Radicava (edaravone)	Revised
06/01/2020	ING-CC-0038*	Human Parathyroid Hormone Agents	Revised
06/01/2020	ING-CC-0067	Prostacyclin Infusion and Inhalation Therapy	Revised
06/01/2020	ING-CC-0075	Rituximab Agents for Non-Oncologic Indications	Revised