April 2021
https://provider.amerigroup.com/wa
Provider Services:
Medicaid: **1-800-454-3730** • Medicare: **1-866-805-4589**

Amerigroup
An Anthem Company

Provider Newsletter

Want to receive
the *Provider Newsletter* via email?
Click here to provide/update your email address.

Table of Contents

WA-NL-0521-21

COVID-19 information from Amerigroup Washington, Inc.

Amerigroup is closely monitoring COVID-19 developments and how the novel coronavirus will impact our customers and provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) and the Washington State Department of Health to help us determine what action is necessary on our part. Amerigroup will continue to follow Washington State Department of Health guidance policies.

For additional information, reference our **website**.

WAPEC-2237-20

Member ID reminders

Amerigroup Washington, Inc. processes all claims under the member's Amerigroup ID. Ensure all claims, including newborn claims, are billed with Amerigroup member ID. Since Amerigroup has different plan products with separate member ID numbers, submitted claim forms will need to list the Amerigroup member ID associated with the services billed.

Newborn claim processing guidelines

Washington state law *RCW 48.43. 115(3)(f)*, known as the *Erin Act*, requires that health plans that provide maternity benefits must provide comparable coverage, at no additional charge, for an insured mother's newborn for up to three weeks (21 days), even if there are separate hospital admissions. The process to comply with RCW is as follows:

- Upon receipt of the first newborn claim, Amerigroup will determine if the Health Care Authority (HCA) has issued the newborn a member ID.
- If the HCA has issued the newborn a member ID, Amerigroup will require the newborn's ID on claims and will process the claims under that ID.
- If the HCA has not yet issued an ID to the newborn, Amerigroup will create a temporary ID to facilitate the processing of the newborn's claims:
  - This temporary ID will remain in place until Amerigroup receives updated eligibility from the HCA.
- Amerigroup does not process newborn claims under the mother's ID:
  - Please ensure that you include the newborn's ID on your claims.

Supportive Housing and Supported Employment Third-Party Administrator (TPA) for Foundational Community Supports (FCS)

Be sure to reference the appropriate ProviderOne* (Medicaid) ID when submitting TPA claims for FCS for reimbursement. The Amerigroup member ID can be used to identify an MCO member with Amerigroup and when calling Provider Services; however, this is not applicable to TPA enrollees with FCS for claims submissions.

For more information on FCS, go to **https://provider.amerigroup.com/washington-provider/patient-care/foundational-community-supports**.

** ProviderOne is an independent company providing learning tools for providers on behalf of Amerigroup Washington, Inc.*

WA-NL-0514-21

Tribal encounter billing issue G48 denials

Amerigroup Washington, Inc. is aware of a claims issue when multiple encounters (T1015) are billed on the same claim for the same dates of service. We are currently denying these claims with a G48 denial code; this denial is happening in error. We are working diligently to correct our claim system logic, and an update will be provided when we have a resolution date providing additional details. In the meantime, you can either split claims by date of service and submit for payment or continue to bill P1.

WA-NL-0502-21

System front end change notification — billing provider and service facility fields require 9-digit ZIP code format

Starting May 1, 2021, all claims must be billed with a 9-digit ZIP code format in the billing provider and service facility fields. On a *CMS-1500* claim, these fields are located in Box 32 (if Box 32 is populated) and in Box 33.

On a *UB-04* claim, this field is located in Box 1. Starting May 1, 2021, any claim submitted without using a 9-digit ZIP code format (5-digit ZIP code plus 4-digit postal code) in these fields will be rejected and not enter our claims adjudication system. Please make any updates necessary to avoid these claim rejections.

WA-NL-0522-21

Messages from the Washington State Health Care Authority

Apple Health (Medicaid) Provider Alert

Attention Applied Behavioral Analysis (ABA) providers:

Effective for dates of service on and after February 1, 2021, applied behavioral analysis (ABA) services are available to eligible clients, regardless of age, who meet the pathway to care steps and are referred for ABA services.

This change will be reflected in the February 1, 2021, **Applied Behavior Analysis (ABA) Billing Guide**.

WA-NL-0519-21

Washington State Saying It Out Loud Conference

New Decade, Bright Asperations: Seeing and Supporting the Whole Person

A conference committed to increasing competency in serving LGBTQ+ individuals and families.

Save the Date: Wednesday, May 26, 2021

Join us in a virtual format!

Join our featured speaker:

Justice G. Helen Whitener
Washington State Supreme Court

Online Registration will open early March 2021.

Watch for an email announcement with registration information or visit the conference website for updates: **SayingItOutLoud.org**

CEUs are available.

To ensure sufficient resources, please let us know any accomodation needs when registering.

WA-NL-0520-21

Wound care treatment request update

Effective April 1, 2021, Amerigroup Washington, Inc. will require all wound care prior authorization (PA) requests contain current clinical documentation. This includes clear documentation of wound care medical necessity including history, effectiveness of treatment and plan of care (POC).

PA requests for wound care services without the below documentation may adversely impact the outcome of the requested services.

Required documentation for a wound care POC must include:

Member information:

- Date the member was last seen by the PCP and/or specialist for the wound/wounds
- The start date of wound treatment
- Determination regarding whether the member was seen by a wound care specialist or at a wound clinic
- Accurate diagnostic information pertaining to the underlying diagnosis and condition, and any other medical diagnoses and conditions (including the member's overall health status)
- Examples:
  - Off-loading pressure and good glucose control for a member with a diabetic ulcer
  - Adequate circulation present for a member with an arterial ulcer
- The member's current and prior permitted functional limitations and activities
- Nutritional deficits or other member needs required for the member
- Dose and frequency of any medications

Description of wound:

- Wound measurements including length, width, depth tunneling and/or undermining
- Wound color, drainage (type and amount) and odor, if present
- Percent of base with granulation tissue
- Whether eschar is present or absent

Wound treatment:

- Description of current wound care regimen including frequency, duration and supplies needed
- Description of all previous wound care therapy regimens (if appropriate)
- If an infection is present, a description of the current treatment regimen
- If wound debridement is prescribed, documentation to support the level and number of debridements
- Documentation indicating if the debridement involves muscle or bone
- Evidence of maintaining a clean, moist bed of granulation tissue

Equipment used for wound treatment:

- Pressure-reducing support surface, mattress and/or cushion
- Compression system (for example, a member with a venous ulcer)
- Wound vac therapy
- Hyperbaric therapy

A physician must see the member within 30 days of the initial start of care and, at minimum, once every six months thereafter, unless the member's condition changes.

A revised POC is required for every change request in home health visits. The revised POC must include all continuing and new orders. It must also be updated to document any changes in the member's condition or diagnosis.

Read more online.

WAPEC-2798-21

Changes to Cancer Care Quality Program effective May 17, 2021

Effective May 17, 2021, Amerigroup Washington, Inc. will no longer participate in the Cancer Care Quality Program administered by AIM Specialty Health®* (AIM). No other AIM program adjustments will be made at this time.

What do I need to do for my patients already receiving medical oncology treatment?

No action is required on your part for Amerigroup members already receiving medical oncology drugs. All medical oncology authorizations issued before May 17, 2021, will be honored through their stated expiration date. However, treatment extensions, regimen changes and new regimens beginning on or after May 17, 2021, require prior authorization (PA) to be submitted to Amerigroup. Providers will **not** lose their access to the AIM ***Provider****Portal*℠ to view their current medical oncology authorizations.

How will new medical oncology PA requests be processed?

Effective May 17, 2021, all review requests for medical oncology drugs, including the codes listed below, will need to be submitted to Amerigroup. Providers will no longer go through the AIM ***Provider****Portal* to submit medical oncology PA requests. For any new medical oncology drugs that become available between now and May 17, 2021, and require PA, please submit these to Amerigroup.

Medical Policies and *Clinical Utilization Management Guidelines* are located on our provider website under Resources. The policies and clinical utilization management guidelines remain the same. The Prior Authorization Lookup Tool is also available on our provider website under Resources > Prior Authorization Lookup Tool.

Prior Authorization requests for medical oncology drugs should be submitted online to Amerigroup. To submit electronic prior authorization (ePA) requests, use CoverMyMeds.* Creating an account is free. While ePA helps streamline the PA process, you may initiate a new PA request by fax or phone. The PA fax number is **1-844-493-9209**, and the form is located on our **website** under Resources > Forms > Prior Authorizations > **Medical Injectables Prior Authorization**. The PA phone number is **1-800-454-3730**.

Read more online.

** AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup Washington, Inc. CoverMyMeds is an independent company providing prior authorization services on behalf of Amerigroup Washington, Inc.*

WA-NL-0503-21

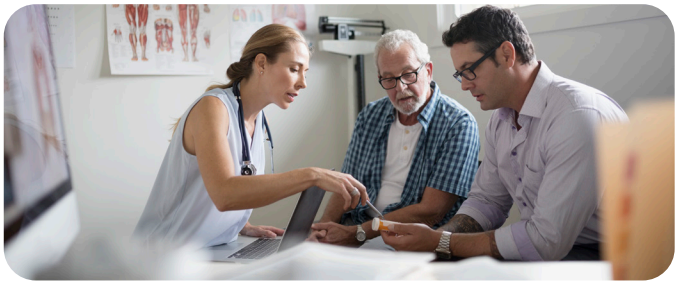
Prior authorization update: attestation out-of-network providers administering COVID-19 vaccination

The COVID-19 vaccine has arrived in our state, and we want to ensure that all providers can be reimbursed for administering the vaccine. The vaccine is federally funded, so while the cost of the vaccine should not be billed to Amerigroup Washington, Inc. for reimbursement, the administration of the vaccination is reimbursable by Amerigroup.

Amerigroup is removing prior authorization requirements for out-of-network providers for the COVID-19 vaccination administration codes below:

CPT®/ HPCPS code	Short description	Labeler	Rate
91300	SARSCOV2 VAC 30MCG/0.3ML IM	Pfizer	0
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST	Pfizer	$16.94
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND	Pfizer	$28.39
91301	SARSCOV2 VAC 100MCG/0.5ML IM	Moderna	0
0011A	ADM SARSCOV2 100MCG/0.5ML 1ST	Moderna	$16.94
0012A	ADM SARSCOV2 100MCG/0.5ML 2ND	Moderna	$28.39

WA-NL-0518-21



Prior authorization updates for specialty pharmacy

Effective for dates of service on and after April 1, 2021, the following medical injectable codes from current or new *Clinical Criteria* documents will be included in our prior authorization review process.

Please note, inclusion of the National Drug Code (NDC) on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

Clinical Criteria	HCPCS or CPT® code(s)	Drug
ING-CC-0164	J9281	**Jelmyto** (mitomycin)
ING-CC-0165	J9317	**Trodelvy** (sacituzumab Govitecan-hziy)
ING-CC-0061	J1950	**Fensolvi** (leuprolide acetate)

WA-NL-0499-20

Visit the ***Clinical Criteria* website** to search for specific *Clinical Criteria*.

Medical Policies and *Clinical Utilization Management Guidelines* update

The *Medical Policies, Clinical Utilization Management (UM) Guidelines* and *Third-Party Criteria* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed.

To view a guideline, visit **https://medicalpolicies.amerigroup.com/am_search.html**.

Notes/updates:

Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

- *GENE.00055 — Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity:
  - Gene expression profiling for risk stratification of inflammatory bowel disease (IBD) severity, including use of PredictSURE IBD, is considered investigational and not medically necessary for all indications
- *LAB.00037 — Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS):
  - Serological testing for biomarkers of irritable bowel syndrome (for example, CdtB and anti-vinculin), using tests such as, IBSDetex, ibs-smart or IBSchek, is considered investigational and not medically necessary for screening, diagnosis or management of irritable bowel syndrome, and for all other indications
- *DME.00011 — Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices:
  - Revised scope to only include non-implantable devices and moved content addressing implantable devices to SURG.00158
  - Added “non-implantable” to bullet point on percutaneous neuromodulation therapy
  - Added percutaneous electrical nerve field stimulation (PENFS) as investigational and not medically necessary for all indications
- *SURG.00062 — Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele:
  - Expanded scope to include percutaneous testicular vein embolization for varicocele and added embolization of the testicular (spermatic) veins as investigational and not medically necessary as a treatment of testicular varicocele
- *CG-LAB-15 — Red Blood Cell Folic Acid Testing:
  - RBC folic acid testing is considered not medically necessary in all cases
- *CG-LAB-16 — Serum Amylase Testing:
  - Serum amylase testing is considered not medically necessary for acute and chronic pancreatitis and all other conditions
- *CG-GENE-04 — Molecular Marker Evaluation of Thyroid Nodules:
  - Added the Afirma Xpression Atlas as not medically necessary
- SURG.00158 – Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain:
  - A new Medical Policy was created from content contained in DME.00011.
  - There are no changes to the policy content.
  - Publish date is December 16, 2020.
- CG-GENE-21 — Cell-Free Fetal DNA-Based Prenatal Testing:
  - A new Clinical Guideline was created from content contained in GENE.00026.
  - There are no changes to the guideline content.
  - Publish date is December 16, 2020.
- The following AIM Specialty Health® (AIM)** *Clinical Appropriateness Guidelines* have been revised and will be effective on April 20, 2021. To view AIM guidelines, visit the **AIM page**:
  - *Advanced Imaging of the Heart
  - *Diagnostic Coronary Angiography

***Medical Policies* and *Clinical Utilization Management Guidelines* update (cont.)**

Medical Policies

On November 5, 2020, the Medical Policy and Technology Assessment Committee (MPTAC) approved several *Medical Policies* applicable to Amerigroup Washington, Inc. These guidelines take effect April 20, 2021.

Clinical UM Guidelines

On November 5, 2020, the MPTAC approved several *Clinical UM Guidelines* applicable to Amerigroup. These guidelines were adopted by the Medical Operations Committee for Amerigroup members on November 19, 2020. These guidelines take effect April 20, 2021.

Read more online.

*** AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup Washington, Inc.*

WA-NL-0501-21

Medical drug benefit *Clinical Criteria* updates

November 2020 updates

On June 18, 2020, August 21, 2020, and November 20, 2020, the Pharmacy and Therapeutics (P&T) Committee approved several *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Washington, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Read more online.

WA-NL-0504-21

December 2020 updates

On December 18, 2020, and December 22, 2020, the Pharmacy and Therapeutics (P&T) Committee approved several *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Washington, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Read more online.

WA-NL-0511-21

Visit the ***Clinical Criteria* website** to search for specific *Clinical Criteria*. If you have questions or would like additional information, reach out via **email**.

Prenatal and Postpartum Care (PPC) including important updates

HEDIS definition:

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Two facets of care are measured:

1. Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization
2. Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Documentation tips:

Prenatal Care Visit

A prenatal care visit should include one of the following options:

- A visit with a diagnosis of pregnancy
- A basic OB exam including one of the following:
  - Auscultation for fetal heart tone
  - Pelvic exam with OB observations
  - Measurement of fundus height
- A visit containing one of the following:
  - Obstetric panel
  - TORCH antibody panel
  - Rubella antibody titer and (ABO/Rh) blood typing
  - Echography (ultrasound) of the uterus
- A visit documenting date of last menstrual period, estimated due date or gestational age with one of the following:
  - Prenatal risk assessment and counseling/education
  - Complete OB histor

Postpartum Care Visit

A postpartum care visit should include one of the following options:

- Pelvic exam
- Evaluation of weight, blood pressure, abdomen and breasts
- Notation of postpartum care:
  - Postpartum care or PP care
  - PP check or six-week check
  - Postpartum care form
- Perineal or cesarean incision/wound check
- Screening for the following:
  - Depression or anxiety
  - Tobacco use or substance use disorder
  - Pre-existing mental health disorder
- Glucose screening for women with gestational diabetes
- Documentation of any of the following:
  - Infant care or breastfeeding
  - Resumption of intercourse or family planning
  - Sleep or fatigue
  - Resumption of physical activity and return to healthy weight

HEDIS spotlight (cont.)

Prenatal Depression Screening and Follow-Up

HEDIS definition:

The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

Two rates are reported:

1. Depression Screening: The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
2. Follow-Up On Positive Screen: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Documentation tips:

Prenatal Depression Screening	The numerator includes deliveries in which members had a documented result of a depression screening performed during pregnancy, using an age-appropriate standardized instrument: ■ Deliveries between January 1 and December 1 of the measurement period: Screening should be performed between the pregnancy start date and the delivery date (including on the delivery date). ■ Deliveries between December 2 and December 31 of the measurement period: Screening should be performed between the pregnancy start date and December 1 of the Measurement Period.
Follow-Up	Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 days total). Any of the following on or up to 30 days after the first positive screen: ■ An outpatient, telephone or e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. ■ A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. ■ A behavioral health encounter, including assessment, therapy, collaborative care or medication management. ■ A dispensed antidepressant medication. OR ■ Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (for example, a negative screen) on the same day as a positive screen on a brief screening instrument.

Postpartum Depression Screening and Follow-Up

HEDIS definition:

The percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care.

Two rates are reported:

1. Depression Screening: The percentage of deliveries in which members were screened for clinical depression during the postpartum period using a standardized instrument.
2. Follow-Up On Positive Screen: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

HEDIS spotlight (cont.)

Documentation tips:	
Postpartum Depression Screening	The numerator includes deliveries in which members had a documented result of a depression screening performed using an age-appropriate standardized instrument during 7 to 84 days following the date of delivery.
Follow-Up	Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 days total). **Any of the following on or up to 30 days after the first positive screen:** ■ An outpatient, telephone or e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. ■ A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. ■ A behavioral health encounter, including assessment, therapy, collaborative care or medication management. ■ A dispensed antidepressant medication. OR ■ Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

NCQA Approved Standardized Instrument for Depression Screening			
Instrument	**Positive finding**	**Adolescents (12-17 years)**	**Adults (18+ years)**
Patient Health Questionnaire (PHQ-9)®	Total score ≥ 10	✓	✓
Patient Health Questionnaire Modified for Teems (PHQ-9M)®	Total score ≥ 10	✓	
Patient Health Questionnaire 2 (PHQ-2)®[2]	Total score ≥ 3	✓	✓
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥ 8	✓	✓
Beck Depression Inventory (BDI-II)	Total score ≥ 20		✓
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥ 17	✓	✓
Duke Anxiety-Depression Scale (DADS)®[1]	Total score ≥ 30		✓
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥ 10	✓	✓
My Mood Monitor (M-3)®	Total score ≥ 5		✓
PROMIS Depression	Total score ≥ 60	✓	✓
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥ 31		✓

1 Proprietary; may be cost or licensing requirement associated with use.
2 Brief screening instrument. All other instruments are full-length.

WA-NL-0510-21

System front end change notification — billing provider and service facility fields require 9-digit ZIP code format

View the **article** in the Medicaid section.

WA-NL-0522-21

In-Office Assessment program

The IOA program is designed to help providers ensure that all active conditions are continuously being addressed and documented to the highest level of specificity for all Medicare Advantage plan patients of providers participating in the program. This program is designed to help improve all patient quality of care (preventive medicine screening, managing chronic illness and prescription management), as well as care for older adults when generated for a Special Needs Plan member.

If you are interested in learning about the electronic modalities available, contact your representative or the Optum* Provider Support Center at **1-877-751-9207**, Monday through Friday, from 8 a.m. to 7 p.m. Eastern time.

Success stories

Below are some achievements that Amerigroup Washington, Inc. was able to accomplish with provider groups through the IOA program:

- As a result of leveraging different types of resources offered by the IOA program (for example, technology), providers' offices were able to see an increase in staff productivity.
- Providers who have taken advantage of the IOA program resources have seen an increase in their documentation and coding accuracy.

COVID-19 update

Amerigroup knows this is a difficult time for everyone, as the situation continues to evolve each day. Amerigroup has considered the severity of the situation and is following CDC guidelines. For the IOA program, all nonessential personal are required to work with provider groups telephonically/electronically until further notice.

Amerigroup continues to evaluate the situation and guidelines, and will keep you notified of any changes.

** Optum is an independent company providing care services on behalf of Amerigroup Washington Inc.*

AGPCRNL-0170-21

Dates and tips to remember:

- To review their population as soon as possible, Amerigroup strongly encourages participating providers to deliver and continually maintain proper care management, as well as care coordination of their patient population. This will further ensure the current and active conditions that impact patient care, treatment and/or management are continually addressed.
- At the conclusion of each office visit with the patient, providers participating in the IOA program are asked to complete and return a patient assessment. The assessment should be completed based on information regarding the patient's health collected during the office visit. Participating providers may continue to use the 2021 version of the assessment for encounters that take place on or before December 31, 2021; Amerigroup will accept the 2021 version of the assessment for 2021 encounters until midnight January 31, 2022.
- If not already submitted, participating providers are required to submit an *Account Setup Form*, *W-9* and completed **direct deposit enrollment** by March 31, 2022. Participating providers should call the Optum Provider Support Center at **1-877-751-9207**, Monday through Friday, from 8 a.m. to 7 p.m. Eastern time, if they have any questions regarding this requirement. Failure to comply with this requirement will result in forfeiture of the provider payment for submitted 2021 assessments, if applicable.

Questions

If you have questions about the IOA program or COVID-19 updates, contact your representative or the Optum Provider Support Center at **1-877-751-9207**, Monday through Friday, from 8 a.m. to 7 p.m. Eastern time.

Oncology Dose Reduction Program beginning July 1, 2021

Amerigroup Washington, Inc. is committed to being a valued healthcare partner in identifying ways to achieve better health outcomes, lower costs and deliver access to better healthcare experiences for consumers.

Effective for dates of service on or after July 1, 2021, providers for our Medicare Advantage plan members covered by Amerigroup will be asked in selective circumstances to voluntarily reduce the requested dose to the nearest whole vial for over 40 oncology medications, listed below. Reviews for these oncology drugs will continue to be administered by the reviewing company, either AIM Specialty Health®* or IngenioRx.*

Providers will be asked whether or not they will accept the dose reduction at the initial review point in the prior authorization process. Within the provider portal, a pop-up question will appear related to dose reduction. If the patient is considered unable to have his or her dose reduced, then a second question will appear asking for the provider's clinical reasoning. For requests made outside of the provider portal (for example, called-in or faxed-in prior authorization requests), the same questions will be asked by the registered nurse or medical director who is reviewing the request. **Since this program is voluntary, the decision made regarding dose reduction will not affect the final decision on the prior authorization.**

The dose reduction questions will appear only if the originally requested dose is within 10% of the nearest whole vial. This threshold is based on current medical literature and recommendations from the Hematology and Oncology Pharmacists Association (HOPA) that it is appropriate to consider dose rounding within 10%. HOPA recommendations can be found **online**.

The Voluntary Dose Reduction Program only applies to specific oncology drugs, listed below. Providers can view prior authorization requirements for Amerigroup members on the ***Medical Policy* and *Clinical Utilization Management Guidelines* page**.

Drug name	HCPCS code
Abraxane (paclitaxel protein-bound)	J9264
Actimmune (interferon gamma-1B)	J9216
Adcetris (brentuximab vedotin)	J9042
Alimta (pemetrexed)	J9305
Asparlas (calaspargase pegol-mknl)	J9118
Avastin (bevacizumab)	J9035
Bendeka (bendamustine)	J9034
Besponsa (inotuzumab ozogamicin)	J9229
Blincyto (blinatumomab)	J9039
Cyramza (ramucirumab)	J9308
Darzalex (daratumumab)	J9145

Drug name	HCPCS code
Doxorubicin liposomal	Q2050
Elzonris (tagraxofusp-erzs)	J9269
Empliciti (elotuzumab)	J9176
Enhertu (fam-trastuzumab deruxtecan-nxki)	J9358
Erbitux (cetuximab)	J9055
Erwinase (asparginase)	J9019
Ethyol (amifostine)	J0207
Granix (tbo-filgrastim)	J1447
Halaven (eribulin mesylate)	J9179
Herceptin (trastuzumab)	J9355
Imfinzi (durvalumab)	J9173

Oncology Dose Reduction Program beginning July 1, 2021 (cont.)

Drug name	HCPCS code
Istodax (romidepsin)	J9315
Ixempra (ixabepilone)	J9207
Jevtana (cabazitaxel)	J9043
Kadcyla (ado-trastuzumab emtansine)	J9354
Keytruda (pembrolizumab)	J9271
Kyprolis (carfilzomib)	J9047
Lartruvo (olaratumab)	J9285
Lumoxiti (moxetumomab pasudotox-tdfk)	J9313
Mylotarg (gemtuzumab ozogamicin)	J9203
Neupogen (filgrastim)	J1442
Oncaspar (pegaspargase)	J9266
Opdivo (nivolumab)	J9299
Padcev (enfortumab vedotin-ejfv)	J9177
Polivy (polatuzumab vedotin-piiq)	J9309
Rituxan (rituximab)	J9312
Sarclisa (isatuximab-irfc)	J9999
Sylvant (siltuximab)	J2860
Treanda (bendamustine)	J9033
Vectibix (panitumumab)	J9303
Yervoy (ipilimumab)	J9228
Zaltrap (ziv-aflibercept)	J9400

Providers should continue to verify eligibility and benefits for all members prior to rendering services

Note: In some plans, *dose reduction to nearest whole vial or waste reduction* may be the term used in benefit plans, provider contracts or other materials instead of or in addition to dose reduction to nearest whole vial. In some plans, these terms may be used interchangeably. For simplicity, we have uses dose reduction (to nearest whole vial).

** AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup Washington, Inc. IngenioRx, Inc. is an independent company providing some utilization review services on behalf of Amerigroup Washington, Inc.*

AGPCRNL-0171-21

Medical drug benefit *Clinical Criteria* updates

November 2020 update

On June 18, 2020, August 21, 2020, and November 20, 2020, the Pharmacy and Therapeutics (P&T) Committee approved several *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Washington, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Read more online.

AGPCRNL-0168-21

December 2020 update

On December 18, 2020, and December 22, 2020, the Pharmacy and Therapeutics (P&T) Committee approved several *Clinical Criteria* applicable to the medical drug benefit for Amerigroup Washington, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

Read more online.

AGPCRNL-0173-21

Visit the ***Clinical Criteria* website** to search for specific policies. If you have questions or would like additional information, reach out via **email**.