

Pharmacy Policy

Methotrexate

Policy Number: 9.125

Revisoin Number: R1

Version Effective Date: 1/1/2021

Product Applicability All Plan+ Products

Well Sense Health Plan

New Hampshire Medicaid

Boston Medical Center HealthNet Plan

MassHealth - MCO

MassHealth - ACO

Qualified Health Plans/ConnectorCare/Employer Choice Direct

Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- Otrexup
- Rasuvo
- Xatmep oral solution

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	Pregnancy or treatment of neoplastic diseases
Required Medical Information	Otrexup, Rasuvo 1. Diagnosis of severe, active polyarticular juvenile idiopathic arthritis (pJIA) OR rheumatoid arthritis (RA); AND

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	<ol style="list-style-type: none"> a. An inadequate response/intolerance to oral methotrexate; AND b. Clinical difficulty with using generic methotrexate solution vials <ol style="list-style-type: none"> 2. Diagnosis of severe, recalcitrant, and disabling psoriasis (Ps); AND <ol style="list-style-type: none"> a. An inadequate response or intolerance to oral methotrexate; AND b. Clinical difficulty with using generic methotrexate solution vials <p>Xatmep oral solution:</p> <ol style="list-style-type: none"> 1. A diagnosis of acute lymphoblastic leukemia (ALL); OR 2. A diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA).
Age Restrictions	Otrexup, Rasuvo: Ps- 18 years of age or older Xatmep: Under 18 years of age
Prescriber Restriction	None
Coverage Duration	12 months
Other criteria	None

Applicable Coding:

None

Clinical Background Information and References

1. Product information. Rasuvo®, methotrexate subcutaneous injection. Medac Pharma. Chicago, IL. March 2018.
2. Product information. Otrexup™, methotrexate subcutaneous injection. Antares Pharma. Ewing, NJ. March 2018
3. Product information. Xatmep (methotrexate). Greenwood Village; Silvergate Pharmaceuticals, Inc; April 2017.
4. Weiss, P.F. Polyarticular juvenile idiopathic arthritis: Treatment. Last updated: October 9, 2018. UpToDate. Waltham, MA: UpToDate Inc. <https://www.uptodate.com> (Accessed on April 1, 2019)

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee, NH DHHS

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Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date	Approved by
6/12/2018	Moved from Policy 9.126 Systemic Immunomodulators	11/01/2018	P&T Committee
05/09/2019	Added Xatmep (methotrexate oral solution) to policy. Changed name from Methotrexate injection to just methotrexate. Xatmep criteria include diagnosis and age under 18.	9/2/19	P&T Committee and NH DHSS
06/11/2020	P&T Annual Review, updated age restriction to match package insert	10/1/2020	P&T Committee and NH DHSS
12/1/2020	9.188 Methotrexate Policy retired, new policy created.	1/1/2021	P&T Committee, NH DHSS

Next Review Date

2021

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

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The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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