HEALTHHELP®
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2025 Medical Oncology

Medical Oncology

MedicalOncology-HH

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Guideline	Guideline Initiated	Previous Review Date	Last Review Date
Antiemetics	06/30/2019	11/29/2024	04/14/2025
Blood/Lymphatic, Bone, Brain/CNS, Breast, GI, GU, GYN, Head/Neck, Hepatobiliary, Lung, Myelodysplastic Syndrome, Occult, Other, Skin, Thymoma/Thymic, Thyroid Cancer	06/30/2019	11/29/2024	04/14/2025
Growth Factors	06/30/2019	01/22/2025	04/14/2025
Sarcomas	06/30/2019	12/02/2024	04/14/2025

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Medical Oncology Drug Coverage

Purpose

To ensure that all medical oncology drug treatments are consistent with established standards of care and evidence-based medicine, this policy outlines the criteria for coverage based on the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®) found at https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia.

Policy Statement

The health plan provides coverage for medical oncology drugs as specified in the NCCN Compendium®. These guidelines are recognized as the gold standard for cancer treatment and are updated regularly to reflect the latest evidence and expert consensus.

Scope

This policy applies to all members receiving medical oncology drug treatments for the following drug categories:

- Antiemetic
- Biologic
- Chemotherapy
- Growth factor
- Hormonal therapy
- Prophylactic therapy

Eligibility Criteria

All the following criteria must be met for coverage.

- Diagnosis: The member must have a confirmed diagnosis of cancer as documented in medical records.
- NCCN Guidelines Compliance: The prescribed drug treatment must be in accordance with the latest NCCN guidelines for the specific type and stage of cancer.
- Medical Necessity: The treatment must be deemed medically necessary by the treating oncologist and consistent with the member's individualized treatment plan.

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- FDA Approval: The drug must be approved by the U.S. Food and Drug Administration (FDA) for the specific indication or be recognized in the NCCN guidelines for off-label use.

NCCN Categories of Evidence and Consensus

Indications and uses of injectable oncology medications, including therapeutic radiopharmaceuticals, are listed in the NCCN Compendium with Categories of Evidence and Consensus outlining the appropriateness of the drug intervention.

Proven and Medically Necessary

- Category 1: Based on high-level evidence, and there is uniform NCCN consensus that the intervention is appropriate.
- Category 2A: Based on lower-level evidence, and there is uniform NCCN consensus that the intervention is appropriate.
- Category 2B: Based on lower-level evidence, and there is major NCCN consensus that the intervention is appropriate.

Unproven and Not Medically Necessary

- Category 3: Based on any level of evidence, and there is divided NCCN consensus that the intervention is appropriate.
- Category 4: Based on any level of evidence, and there is major NCCN consensus that the intervention is inappropriate.
- Category 5: Based on any level of evidence, and there is uniform NCCN consensus that the intervention is inappropriate.

Covered Drugs

The following drugs are considered covered when ordered and administered in accordance with the NCCN Compendium. The following list of medications is provided for reference purposes only and may not be all inclusive. Listing of a medication in this policy does not imply that it is a covered or non-covered health service. Benefit coverage is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service.

ado-trastuzumab emtansine	cabazitaxel
aprepitant	carboplatin
atezolizumab	carfilzomib
avelumab	cemiplimab-rwlc
azacitidine	cetuximab
BCG live intravesical instillation	cisplatin, powder or solution
bevacizumab-awwb (Mvasi)	daratumumab

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bevacizumab-bvzr (Zirabev)	daratumumab and hyaluronidase-fihj
bortezomib (Velcade)	darbepoetin alfa
brentuximab vedotin	decitabine
degarelix	octreotide
denosumab	oxaliplatin
docetaxel	paclitaxel
doxorubicin hydrochloride	paclitaxel protein-bound particles
doxorubicin hydrochloride, liposomal	palonosetron hcl
durvalumab	panitumumab
eflapegrastim-xnst	pegfilgrastim
elotuzumab	pegfilgrastim-apgf (Nyvepria)
enfortumab vedotin-ejfv	pegfilgrastim-bmez (Ziextenzo)
epoetin alfa	pegfilgrastim-cbqv (Udenyca)
epoetin alfa (Retacrit)	pegfilgrastim-jmdb (Fulphila)
fam-trastuzumab deruxtecan-nxki	pembrolizumab
filgrastim (g-CSF)	pemetrexed
filgrastim-aafi (Nivestym)	pertuzumab, trastuzumab, and hyaluronidase-zzxf
filgrastim-sndz (Zarxio)	rituximab
fluorouracil	rituximab-abbs (Truxima)
fosaprepitant	rituximab-pvvr (Ruxience)
fosnetupitant and palonosetron	sacituzumab govitecan-hziy
fulvestrant	tbo-filgrastim
gemcitabine hydrochloride	topotecan
goserelin acetate implant	trastuzumab
granisetron hydrochloride	trastuzumab-anns (Kanjinti)
irinotecan	trastuzumab-dkst (Ogivri)
lanreotide	trastuzumab-qyyp (Trazimera)
leuprolide acetate	trilaciclib
leuprolide injectable, camcevi	triptorelin pamoate
lurbinectedin	vincristine sulfate
mitomycin	zoledronic acid
nivolumab	
obinutuzumab	

NOTE: Any U.S. Food and Drug Administration approved product that may belong to the included NCCN drug categories but not listed by name in this policy will undergo an individual Prior Authorization review.

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Pediatric Coverage

All chemotherapy agents for individuals under the age of 19 years for oncology indications are considered covered. Most pediatric patients receive treatments on national pediatric protocols that are quite similar in concept to the NCCN patient care guidelines.

Medicare Advantage Coverage

Coverage determinations for Medicare Advantage members will follow the Commercial guidelines above except where an NCD or LCD/LCA published by CMS outlines different criteria. Refer to the NCD Anti-Cancer Chemotherapy for Colorectal Cancer (110.17) https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=291&ncdver=1&bc=0 or the following LCDs/LCAs at: https://www.cms.gov/medicarecoverage-database/new-search/search.aspx:

- Billing and Coding: Additional Claim Documentation Requirements for Not Otherwise Classified (NOC) Drugs and Biological Products with Specific FDA Label Indications
- Billing and Coding: Xofigo Billing Instructions
- Drugs and Biologicals, Coverage of, for Label and Off-Label Uses
- Luteinizing Hormone-Releasing Hormone (LHRH) Analogs
- Rituximab
- Trastuzumab – Trastuzumab Biologics

Exclusions

The following are excluded from coverage:

- Experimental or investigational drugs not included in the NCCN Compendium.
- Treatments not approved by the FDA for the specific indication unless supported by NCCN Compendium for off-label use.
- Drugs prescribed for conditions not related to the member's cancer diagnosis.

Medical Oncology Summary of Changes

Medical Oncology guideline from 2024 to 2025 had the following changes:

- Combined all of medical oncology into one policy

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Disclaimer section

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.
CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.
In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

For Internal Use Only:

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