KAISER PERMANENTE®

206-988-2000
206-988-2001
prnotification@kp.org

Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
CONTRACT MANAGER NAME
Provider Communications, RCB-C2W-02
PO Box 34262, Seattle WA 98124-1262

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ALGLUCOSIDASE (LUMIZYME) IN THE HOME INFUSION SETTING RESTRICTED TO ADMINISTRATION BY KAISER PERMANENTE HOME INFUSION

Dear Provider,

Effective September 1, 2020, the criteria for the specialty home infusion products listed in Table 1 will change. For home infusion, these specialty home infusion products and administration of these products is limited to Kaiser Permanente Home Infusion for **non-Medicare** Health Maintenance Organization (HMO) members.

Table 1. List of Specialty Home Infusion Products that are limited to administration by Kaiser Permanente Home Infusion

BRAND NAME	GENERIC NAME	HCPCS
LUMIZYME	ALGLUCOSIDASE	J0221

To transition any patients or for additional questions specific to this change, contact Kaiser Permanente Home Infusion by telephone at 206-326-2990.

The criteria for outpatient standalone clinic, infusion center, provider's office, and hospitals are not affected. Hospital outpatient settings require site of care approval.

Prior authorization is still required for these drugs, and the prior authorization criteria is outlined below for the specialty home infusion products listed in Table 1. Kaiser Foundation Health Plan of Washington requires prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Foundation Health Plan of Washington's Medical Policy Committee.

Prior Authorization Criteria for Alglucosidase (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
LUMIZYME	1. Covered for FDA approved indications. 2. **For home infusion, the in-network benefit is available only if administered by Kaiser Permanente Home Infusion. Please submit a referral to KPHIS at 206-326-2139.** Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients <13 years old.

NATALIZUMAB (TYSABRI) IN THE HOME INFUSION SETTING RESTRICTED TO ADMINISTRATION BY KAISER PERMANENTE HOME INFUSION

Effective September 1, 2020, the criteria for the specialty home infusion products listed in Table 1 will change. For home infusion, these specialty home infusion products and administration of these products is limited to Kaiser Permanente Home Infusion for **non-Medicare** Health Maintenance Organization (HMO) members.

Table 1. List of Specialty Home Infusion Products that are limited to administration by Kaiser Permanente Home Infusion

BRAND NAME	GENERIC NAME	HCPCS
TYSABRI	NATALIZUMAB	J2323

To transition any patients or for additional questions specific to this change, contact Kaiser Permanente Home Infusion by telephone at 206-326-2990.

The criteria for outpatient standalone clinic, infusion center, provider's office, and hospitals are not affected. Hospital outpatient settings require site of care approval.

Prior authorization is still required for these drugs, and the prior authorization criteria is outlined below for the specialty home infusion products listed in Table 1. Kaiser Foundation Health Plan of Washington requires prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Foundation Health Plan of Washington's Medical Policy Committee.

Prior Authorization Criteria for Natalizumab (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
TYSABRI	3. Approved for patients with the following: • Diagnosis of a relapsing form of MS per the McDonald criteria AND • Failure or intolerance to either beta-interferon or glatiramer. Minor injection site reactions are not considered medication failure. OR • Diagnosis of a relapsing form of MS per the McDonald criteria AND • Evidence of highly active disease. 4. Not covered for other types of MS or for Crohn's disease. 5. **For home infusion, the in-network benefit is available only if administered by Kaiser Permanente Home Infusion. Please submit a referral to KPHIS at 206-326-2139.** Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients <13 years old.

Additional Information

A complete list of office-administered injectable and specialty home infusion drugs requiring prior authorization is available on Kaiser Permanente for Providers at https://wa-provider.kaiserpermanente.org/provider-manualunder Authorization & Clinical Review.

You can request authorization using one of the following methods:

- Use the Kaiser Permanente for Providers web site. You can send your request for authorization using our Referral Request tool. Using this method is easy and is the quickest way to obtain your authorization, sometimes immediately if your request is auto approved.
- Fax your request to the Review Services department at 1-888-282-2685.

- Contact Review Services at 1-800-289-1363, Monday – Friday from 8 am to 5 pm. After business hours, please leave a voice message with your contact information. Messages received after normal business hours are returned on the next business day.

Sincerely,

Marc Mora, MD
Senior Medical Director Networks and Care Management
Washington Permanente Medical Group