

Cigna National Preferred Formulary Coverage Policy



Effective Date 1/1/2021
Next Review Date... 1/1/2022
Coverage Policy Number NPF136

Drug Quantity Management - Per Days Medications for Coronavirus 2019 (COVID-19) Infections Anti-stockpiling – Retail Claims Only

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Related Coverage Resources

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

NPF Coverage Policy

Cigna covers quantities as medically necessary when the following criteria are met:

Drugs Affected:

- chloroquine tablets – generics
- hydroxychloroquine tablets (Plaquenil®, generics)
- lopinavir/ritonavir tablets, oral solution (Kaletra®)

The purpose of this policy is to prevent the stockpiling, misuse and/or overuse of the above medications. For coverage of additional medication, prior authorization is required.

Table 1

Generic name	Medication allowed per 365 day period
chloroquine 250 mg tablets	56 tablets
chloroquine 500 mg tablets	28 tablets
Plaquenil (hydroxychloroquine) 200 mg tablets	30 tablets
Kaletra 200 mg/50 mg tablets	56 tablets
Kaletra 100 mg/25 mg tablets	112 tablets
Kaletra 80 mg-20 mg/ml oral solution	160 ml (1 bottle)

Criteria

Approval duration as noted below in criteria.

chloroquine 250 mg tablets

1. Individuals who need malaria prophylaxis therapy, a quantity sufficient to allow up to 500 mg (2 tablets) weekly for a period of 2 weeks before entering a malaria endemic area and continue 500 mg (2 tablets) weekly during the stay in the endemic area and 500 mg (2 tablets) weekly for 8 weeks after return from the endemic area may be approved.

chloroquine 500 mg tablets

1. Individuals who need malaria prophylaxis therapy, a quantity sufficient to allow up to 500 mg (1 tablet) weekly for a period of 2 weeks before entering a malaria endemic area and continue 500 mg (1 tablet) weekly during the stay in the endemic area and 500 mg (1 tablet) weekly for 8 weeks after return from the endemic area may be approved.

Plaquenil 200 mg tablets

1. Individuals who need malaria prophylaxis therapy, a quantity sufficient to allow up to 400 mg (2 tablets) weekly for a period of 2 weeks before entering a malaria endemic area and continue 400 mg (2 tablets) weekly during the stay in the endemic area and 400 mg (2 tablets) weekly for 4 weeks after return from the endemic area may be approved.
2. For individuals with rheumatoid arthritis (RA), lupus erythematosus (discoid, systemic), or lupus nephritis, up to 90 tablets per 30 days may be approved for 12 months.

Kaletra 200/50 mg tablets, 100/25 mg tablets, 80/20 mg per ml oral solution

1. Individuals who are using Kaletra for the treatment of HIV-1 infection, approve the requested amount.

Conditions Not Covered

Any other exception is considered not medically necessary

Background

Overview

The medications listed in Table 1 above are approved use in the treatment of several different diseases including various parasitic diseases, rheumatoid arthritis (RA), lupus erythematosus (discoid, systemic), and HIV-1 infection.¹⁻³

The purpose of this policy is to prevent the stockpiling, misuse and/or overuse of the above medications. For coverage of additional medication, prior authorization is required.

References

1. Chloroquine tablets [prescribing information]. Jacksonville, FL: Ranbaxy Pharmaceuticals Inc.; December 2013.
2. Plaquenil tablets [prescribing information]. St. Michael, Barbados: Concordia Pharmaceuticals Inc.; June 2018.
3. Kaletra tablets, oral solution [prescribing information]. North Chicago, IL: AbbVie Inc.; December 2019.
4. Dong L, Hu S, Gao J. Discovering drugs to treat coronavirus disease 2019 (COVID-19). Drug Discoveries & Therapeutics 2020; 14(1):58-60.
5. Hydroxychloroquine. Clinical Pharmacology [Internet]. Tampa (FL): Elsevier. c2020 – [cited 2020 March 20]. Available from: <http://www.clinicalpharmacology.com>.

Last Revision Details

Selected Revision	Removed COVID-19 criteria. Reviewed and approved at TAC.	04/08/2020
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