evolent	**DESKTOP PROCEDURE**
Desktop Procedure Name: Blue Shield of California Medical Oncology Drug List	
Desktop Procedure #: CO.328	**Department: Clinical Operations**
Date of Development: 9/26/2025	**Date(s) of Revision:**
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APPLICABILITY

This DTP has been created to describe how the Health Plan Medical Oncology Drug List will be used for Utilization Management determinations (e.g., approvals, RADs, withdrawals etc.) for drugs/regimens used to treat Oncology/Hematology conditions.

PROCEDURE

DEFINITIONS

Health Plan Medical Oncology Preferred Drug List for Oncology/Hematology:

- This is a list of preferred drug alternatives when more than one drug/agent is available for a specific diagnosis. The latter drug(s) may be a biosimilar (e.g., bevacizumab biosimilars), belong to the same drug class (e.g., Erythropoiesis-Stimulating Agents), or be used for the same diagnosis (e.g., iron deficiency, bone metastases).

Procedure

I. Commercial

1. Evolent will perform utilization review of a requested medical oncology drug/regimen and, depending on the contracted utilization management services, (i) recommend denial or authorization of coverage of the drug/regimen; or (ii) issue the denial or authorization of coverage of the drug/regimen. Medications that are new to the market will be non-preferred, with prior authorization required, until reviewed by the Health Plan.

   Notwithstanding anything in this policy to the contrary, subject to legal and regulatory requirements, the member specific benefit plan document always controls when determining coverage.

2. Drugs that are not included as a preferred drug on the Health Plan Medical Oncology Drug

List will not be authorized for coverage unless the non-preferred drug meets exception criteria for coverage.

3. Exception criteria for coverage include: a state, federal, or health plan mandate to cover the drug, when the preferred drug is not available due to a documented drug shortage, contraindication, confirmed intolerance, or lack of efficacy to a preferred drug/regimen. The FDA maintains the database of current drug shortages, which, as of the date of this Policy, may be found at www.fda.gov/drugs/drug-safety-and-availability/drug-shortages.

   Approval or recommendation that a non-preferred drug meets exception criteria for coverage is not a guarantee of coverage. All other member-specific requirements for coverage must be met for the non-preferred drug to be covered for the specific member, including, but not limited to, valid and current member enrollment.

   Continuation requests of previously approved, non-preferred medication are not subject to the above restrictions.

II. Medicare

1. For Medicare populations and indications for approving a request for medical necessity will be determined based on the following medical review hierarchies:
   a. National Coverage Determination guidelines and Local Coverage Determination guidelines, if applicable.
   b. Compendia or Guidelines:
      i. American Hospital Formulary Service-Drug Information (AHFS-DI) Compendium
      ii. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
      iii. Micromedex Compendium
      iv. Clinical Pharmacology Compendium
      v. Lexi-Drug Compendium
      vi. American College of Cardiology (ACC)
      vii. Peer reviewed literature support
2. Step Therapy and/or Preferred Drug Guidance: Evolent will take into account any Step Therapy or Preferred Drug Guidance set forth by the client health plan when processing authorizations.
3. Established policies: Evolent, or client policy when contractual agreement exists. For Medicare populations, such coverage criteria may not be more restrictive than any applicable NCD or LCD. The MCD should be monitored on an ongoing basis for NCDs, LCDs and related publications.

III. Standards

Evolent will review whether the requested drug/regimen should be authorized for coverage by applying the following standards in this order:

1. Applicable state and federal laws, rules, regulations, including but not limited to, state and federal mandated coverage requirements, and government program

requirements.

2. Health plan (Exchange/Commercial) coverage criteria provided by the health plan to Evolent, including, but not limited to a health plan specific drug list, formulary, and coverage criteria.
3. The Health Plan Medical Oncology Drug List (including the clinical criteria applicable to the drugs included on the list).

REVISION DATES

This DTP had been created for Blue Shield of CA, in substitution of the policy MOD 0001 Medical Oncology Drug List, which was retired in September 2025.	September 2025