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Pharmacy Policy

Non-Preferred PDL Drug Requests

Policy Number: 9.055
Revision Number: R0
Version Effective Date: 1/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan ☒ New Hampshire Medicaid ☐ _____	**Boston Medical Center HealthNet Plan** ☐ MassHealth ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options ☐ _____

Policy Summary

The Plan will authorize coverage of non-preferred medications when appropriate criteria are met.

Description of Item or Service

The drug formulary was developed as a means to assure quality clinical care concurrent with pharmacy management. All non-preferred drugs on the Preferred Drug List (PDL) require prior authorization and are subject to quantity limitations.

Policy

The Plan may authorize coverage of non-preferred medications for members meeting the following criteria:

Initial Criteria *See below for criteria for branded	1. Allergy to all medications within the same class on the PDL; OR 2. Contraindication to or drug-to-drug interaction with all medications within the same class on the PDL; OR 3. History of unacceptable or toxic side effects to all medications within the same class

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan

products with generics available	on the PDL; OR 4. Therapeutic failure of all medications within the same class on the PDL; OR 5. An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal FDA approved indication; OR 6. An age-specific indication, Medical co-morbidity or other medical complication that precludes the use of a preferred drug; OR 7. Clinically unacceptable risk with a change in therapy to a preferred drug.
Requests for Brand-name medications with generic equivalents	Documentation of the following: 1. An allergy to one of the inactive ingredient(s) found in the generic version(s) of the medication that is not found in the brand name medication; ***AND*** 2. An inadequate response or intolerance to a trial of at least two other preferred alternatives (one if less than two available) within the same therapeutic class as the requested medication.
Continuation of Therapy	Documentation of the following: 1. Initial criteria is met; ***AND*** 2. Clinically unacceptable risk with a change in therapy to a covered agent; ***AND*** 3. Compliance with the requested therapy and the clinical condition has improved or stabilized without treatment-related adverse events
Duration of Approval	1 year

Limitations

The Plan will ***not*** approve coverage of non-preferred medications in the following instances:

- When the criteria above has not been met
- Continuation of medications that a member has been receiving may not be considered medically necessary for the following
    - Patient has received manufacturer supplied samples from the prescriber; OR
    - Patient has utilized a manufacturer's free coverage assistance programs or copay assistance programs to establish therapy

Clinical Background Information and References

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

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	Updated policy number; No other changes	1/1/2021	P&T Committee, NH DHHS
03/14/2019	P&T Annual Review: No changes recommended	07/01/2019	P&T Committee, NH DHHS

Next Review Date

2021

Other Applicable Policies

Definitions

New Hampshire Medicaid Care Management Program Contract Definitions of Medically Necessary (for the Well Sense Health Plan Products):

1. For Well Sense Health Plan members 21 years of age and older: Health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

    a. Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms; AND

    b. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider; AND

c. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; AND

d. Not experimental, investigative, cosmetic, or duplicative in nature.

2. For Well Sense Health Plan members under age 21 (i.e., until the member's 21st birthday): Health care services reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) recipient requesting a medically necessary service.

Reference to Applicable Laws and Regulations, If Any

1. Contract between the New Hampshire Department of Health and Human Services and Plan.

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.

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.