WELL SENSE HEALTH PLAN

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Pharmacy Policy

Non-Formulary Exceptions

Policy Number: 9.051
Revision Number: R0
Version Effective Date: 3/3/2021

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 drugs not on the formulary 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-formulary drugs are not on the formulary and require prior authorization.

Policy

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

Approval Criteria	1. Drug is being used for an FDA approved indication(s) or medically accepted indication(s) supported by compendia*; ***AND*** 2. **<u>One</u>** of the following:

+ *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

	a. Documented trial and failure of at least two (2) formulary drugs within the same therapeutic class or recognized as clinically accepted alternatives for treatment of the same diagnosis; ***OR*** b. Allergy to all medications within the same class on the formulary; ***OR*** c. Contraindication to or drug-to-drug interaction with all medications within the same class on the formulary; ***OR*** d. History of unacceptable or toxic side effects to all medications within the same class on the formulary; ***OR*** e. An age-specific indication, Medical co-morbidity or other medical complication that precludes the use of a formulary drug; ***OR*** f. Clinically unacceptable risk with a change in therapy to a formulary drug.
Duration of Approval	1 year

Limitations

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

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	Policy 9.080 Discontinued. Created new policy.	1/1/2021	P&T Committee NH DHHS
3/3/2021	Verbiage change made to replace 'PDL' with 'Formulary'	3/3/2021	P&T Committee, NH DHHS

Next Review Date

2021

Other Applicable Policies

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.