Clinical Policy: Request for Medically Necessary Drug Not on the PDL

Reference Number: CP.PMN.16
Effective Date: 09.01.06
Last Review Date: 11.24
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The intent of the criteria is to ensure that members follow selection elements established by Centene for drugs that are not on the preferred drug list (PDL).

FDA Approved Indication(s)

Varies by drug product.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that non-PDL drugs are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria*

For members in **Nevada, medical management techniques, including quantity management, beyond step therapy is not allowed for medication-assisted treatment (MAT)/withdrawal, HIV, and hepatitis C drugs*

A. Request for a Non-PDL Drug (must meet all)**:**

1. Prescribed indication is FDA-approved;*
   **Requests for off-label use should also be reviewed against CP.PMN.53 – Off-Label Drug Use*
2. Request is not for a benefit excluded use (e.g., cosmetic);
3. Failure of at least two preferred agents within the same therapeutic class that are FDA-approved for the same indication and/or drugs that are considered the standard of care for the indication, when such agents exist, at up to maximally indicated doses, each used for the appropriate duration of treatment or for ≥ 30 days for diseases requiring maintenance treatment, unless one of the following (a, b, or c):
   a. Clinically significant adverse effects are experienced or all are contraindicated;
   b. Request is for treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D);*
   c. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings (*see Appendix E*);
4. Trial and failure of preferred agents is supported by one of the following (a, b, c, or d):
   a. Presence of claims in pharmacy claims history supporting failure of preferred agents as described in criterion 3 above;
   b. Documented contraindication(s) or clinically significant adverse effects to **all** preferred agents within the same therapeutic class or preferred drugs that are recognized as standards of care for the treatment of member's diagnosis;

c. Drug sample logs which include all of the following: medication name, dose/strength, lot number, expiration date, quantity dispensed, date sample was provided, and initials/title of the dispenser;
d. Documentation in provider chart notes which include all of the following: medication name, dose/strength, and start/end dates of therapy;

5. For combination product or alternative dosage form or strength of existing drugs, one of the following (a, b, or c):
   a. Medical justification* supports inability to use the individual drug products concurrently or alternative dosage forms or strengths (e.g., contraindications to the excipients of all alternative products);
   b. Request is for treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D);*
   c. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings (*see Appendix E*);

   **Use of a copay card or discount card does not constitute medical necessity*
6. Request meets one of the following (a or b):
   a. Dose does not exceed the FDA approved maximum recommended dose for the relevant indication and health plan approved daily quantity limit;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: Duration of request or 12 months (whichever is less)

II. Continued Therapy*

** For members in **Nevada**, medical management techniques, including quantity management, beyond step therapy is not allowed for medication-assisted treatment (MAT)/withdrawal, HIV, and Hepatitis C drugs*

A. Request for a Non-PDL Drug (must meet all)**:**

1. One of the following (a, b, or c):
   a. Currently receiving medication via Centene benefit;
   b. Member has previously met initial approval criteria;
   c. State or health plan continuity of care programs apply to the requested drug and indication (e.g., seizures, heart failure, human immunodeficiency virus infection, psychotic disorders [e.g., schizophrenia, bipolar disorder], depression, transplant, oncology) with documentation that supports that member has received this medication for at least 30 days (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed the FDA-approved maximum recommended dose for the relevant indication and health plan approved daily quantity limit;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

III. Diagnoses/Indications for which coverage is NOT authorized: Not applicable

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
PDL: preferred drug list

Appendix B: Therapeutic Alternatives
Varies by drug product

Appendix C: Contraindications/Boxed Warnings
Varies by drug product

Appendix D: States with Limitations against Redirections in Certain Settings

State	Step Therapy Prohibited?	Notes
AR	Yes	For the treatment of psychosis and serious mental illness through antipsychotic prescription drugs, no step therapies allowed.
NV	No	For typical or atypical antipsychotic or anticonvulsant medications, step therapy is limited to one PDL drug.

Appendix E: States with Regulations against Redirections in Cancer

State	Step Therapy Prohibited?	Notes
FL	Yes	For stage 4 metastatic cancer and associated conditions.
GA	Yes	For stage 4 metastatic cancer. Redirection does not refer to review of medical necessity or clinical appropriateness.
IA	Yes	For standard of care stage 4 cancer drug use, supported by peer-reviewed, evidence-based literature, and approved by FDA.
LA	Yes	For stage 4 advanced, metastatic cancer or associated conditions. Exception if "clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy.
NV	Yes	Stage 3 and stage 4 cancer patients for a prescription drug to treat the cancer or any symptom thereof of the covered person
PA	Yes	For stage 4 advanced, metastatic cancer
TN	Yes	For advanced metastatic cancer and associated conditions
TX	Yes	For stage 4 advanced, metastatic cancer and associated conditions

V. Dosage and Administration

Varies by drug product

VI. Product Availability

Varies by drug product

VII. References

Not applicable

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2020 annual review: no significant changes; added bypass of required preferred agent trials if clinically significant adverse effects are experienced or all are contraindicated; clarified claims history for non-PDL drug requests must support requirements for failure of preferred agents; references reviewed and updated.	07.13.20	11.20
4Q 2021 annual review: no significant changes; added clarification and reference to off-label use policy.	07.22.21	11.21
4Q 2022 annual review: no significant changes.	08.02.22	11.22
Added reference to CC.PHARM.03A and CC.PHARM.03B to Section II for state or health plan continuity of care programs.	02.06.23	
Added bypass of preferred agent and combination products redirection if request is for treatment of a member in a State with limitations on step therapy in certain mental health settings along with Appendix D, which includes Arkansas.	07.05.23	
Added Nevada to Appendix D with the following step therapy limits: For typical or atypical antipsychotic or anticonvulsant medications, step therapy is limited to one PDL drug.	08.31.23	
4Q 2023 annual review: added requirement that request is not for a benefit excluded use.	09.01.23	11.23
Added disclaimer that medical management techniques, including quantity management, beyond step therapy is not allowed for members in NV per SB 439.	05.28.24	
4Q 2024 annual review: added bypass of preferred agent and combination products redirection if request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings along with Appendix E; added depression and transplant to list of continuity of care programs per current Centene standard approach.	07.29.24	11.24

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.