EVOLENT HEALTH LLC
EVOLENT MEDICAL ONCOLOGY DRUG LIST POLICY

POLICY TITLE: **Medical Oncology Drug List**
DEPARTMENT: **Medical Oncology**
ORIGINAL DATE: **November 2023**

Approvers: Evolent Specialty Services Clinical Guideline Review Committee

Department: Medical Oncology

Impacted Business Areas: Medicaid, Commercial/Exchange (Risk & Non-Risk)

Product Applicability:
- ☐ All
- ☒ Commercial / Exchange
  - ☐ Other _____
- ☐ Corporate
- ☒ Medicaid
- ☐ Medicare
  - ☐ All
  - ☐ Medicare Advantage
  - ☐ Medicare Part C
  - ☐ Medicare Part D
  - ☐ Special Needs Plan _____
- ☐ Self-Funded / ASO
- ☐ Other _____

State Applicability:

☒ All	☐ Montana
☐ Alabama	☐ Nebraska
☐ Alaska	☐ Nevada
☐ Arizona	☐ New Hampshire
☐ Arkansas	☐ New Jersey
☐ California	☐ New Mexico
☐ Colorado	☐ New York
☐ Connecticut	☐ North Carolina
☐ Delaware	☐ North Dakota
☐ Florida	☐ Ohio
☐ Georgia	☐ Oklahoma
☐ Hawaii	☐ Oregon
☐ Illinois	☐ Pennsylvania
☐ Idaho	☐ Rhode Island
☐ Indiana	☐ South Carolina
☐ Iowa	☐ South Dakota
☐ Kansas	☐ Tennessee
☐ Kentucky	☐ Texas
☐ Louisiana	☐ Utah
☐ Maine	☐ Vermont
☐ Maryland	☐ Virginia
☐ Massachusetts	☐ Washington
☐ Michigan	☐ West Virginia
☐ Minnesota	☐ Wisconsin
☐ Mississippi	☐ Wyoming
☐ Missouri	

REGULATORY REQUIREMENTS

- Applicable state and federal law, regulation and program guidance pertaining to the utilization review of the applicable medical oncology drugs.

RELATED DOCUMENTS

- Individual Drug Policies- Medical Oncology & Hematology

PURPOSE

To describe how the Evolent Medical Oncology Drug List will be used for Utilization Management determinations (e.g., approvals, RADs, withdrawals etc.) for Evolent clients that use Evolent Clinical Policies for UM determinations or recommendations/Prior Authorizations for drugs/regimens used to treat Oncology/Hematology conditions.

DEFINITIONS

Evolent Medical Oncology 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 either be a biosimilar (e.g., bevacizumab biosimilars), belong to the same drug class (e.g., Tyrosine Kinase Inhibitors for Chronic Myeloid Leukemia) or may be used for the same diagnosis (e.g., Bone Metastases).

POLICY:

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.

   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 Evolent Medical Oncology Drug List will not be authorized for coverage unless the non-preferred drug meets exception criteria for coverage. 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, or confirmed intolerance 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.

PROCEDURE

Evolent will review whether the requested drug/regimen should be authorized for coverage 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 (Medicaid/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. This Policy does not apply to Medicare Advantage. For guidance regarding utilization management requirements for Medicare Advantage, please see the applicable Medicare Advantage utilization management policy.
3. The Evolent Medical Oncology Drug List (including the clinical criteria applicable to the drugs included on the list).

APPLICABILITY

This Medical Oncology Drug List policy applies to all clients who have contractually agreed to use Evolent Oncology Policies for their Medicaid, Commercial, and/or Exchange lines of business.

Evolent reserves the right to modify its Policies and Procedures as it determines what is necessary.

COMPLIANCE

Workforce members are required to comply with all Evolent policies and procedures as a condition of employment / contract with Evolent. Workforce members who fail to abide by requirements outlined in Evolent policies and procedures are subject to disciplinary action up to and include termination of employment / contract.

RECORD RETENTION

Records Retention for Evolent documents, regardless of medium, are provided within the Evolent records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.
This Policy will be reviewed at least annually. The policy will be available on Evolent SharePoint. The Evolent Oncology Pharmacy Team will also maintain this policy. Policy will be available for review by clients and providers.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	REVISION DATE
New Policy created to clearly define the use of the Evolent Medical Oncology Drug List for Oncology/Hematology pharmaceutical requests	11/2023
Consolidated policy MP.001.E with this policy, and retired MP.001.E	04/2025
Annual Review	07/2025