Policy Title:	General Prior Authorization form for medically administered medications		
		Department:	PHA
Effective Date:	02/13/2019		
Review Date:	2/13/2019, 09/28/2020, 02/11/2021, 2/10/2022, 2/1/2023		
Revision Date:	09/28/2020, 02/11/2021		

Purpose: To support safe, effective and appropriate use of medically administered medications that do not have drug specific criteria.

Scope: Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

Policy Statement:

For all medically administered medications (without drug specific criteria) under the Medical Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

Procedure:

Initial Criteria Coverage:

- The medically administered medication is being used for an FDA approved indication or a medically accepted indication as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or peer-reviewed published medical literature indicating that sufficient evidence exists to support use; AND
- The medically administered medication is being dosed according to FDA guidelines; AND
- The medically administered medication is being requested with the correct HCPCS code and units; AND
- All relevant documentation (e.g., lab values, treatment plan, medical chart notes) is provided
- Patient must follow established clinical practice guidelines for treatment of their medical condition; AND
- If requesting a reference product when a biosimilar product is available, the patient must have failure, intolerance or contraindication to the biosimilar product unless such therapies do not exist; OR
- The patient has experienced an inadequate treatment response or intolerance to all first line agents, including the generic, if available; OR

MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

Continuation of therapy:

- Patient meets all initial criteria; AND
- Patient is tolerating treatment and is not experiencing any unacceptable toxicity from the drug; AND
- Patient has disease stabilization or improvement in disease (as defined by established clinical practice guidelines).

Coverage durations:

- Initial coverage criteria = 6 months
- Continuation of therapy = 6 months

Investigational Use: All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug Information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.