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, 12/07/2023, 01/04/2024		

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

Per §§ 42 CFR 422.101, this clinical medical policy only applies to INTEGRITY in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD).

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.

References

1. NHPRI Formulary Management Policy and Procedure.