nh healthy families

MEDICAL NECESSITY GUIDELINE

DEPARTMENT: Pharmacy	**DOCUMENT NAME:** Request for Medically Necessary Drug not on the PDL
PAGE: 1 of 3	**REFERENCE NUMBER:** NH.PMN.16
EFFECTIVE DATE: 09/15	**REPLACES**
RETIRED:	**REVIEWED:** 08/16, 07/17
PRODUCT TYPE: All	**REVISED:**

IMPORTANT REMINDER

This Clinical Policy has been developed by appropriately experienced and licensed health care professionals based on a thorough review and consideration of generally accepted standards of medical practice, peer-reviewed medical literature, government agency/program approval status, and other indicia of medical necessity.

The purpose of this Clinical Policy is to provide a guide to medical necessity. Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits ("Benefit Plan Contract") and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding results. 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.

Description: Drugs not on the Preferred Drug List (PDL) are medications that require review before they are approved for use. They are generally drugs that have been reviewed by the Centene Pharmacy and Therapeutics Committee and believed to be second line therapy as compared to PDL agents. This guideline is designed for drugs without specific approval criteria.

Brands or Generics: Various drug products.

FDA Labeled Indications: Refer to the FDA approved indication(s) or indication(s) supported by evidence-based studies.

Criteria for A. Documented trial and failure of at least two (2)* PDL

nh healthy families

MEDICAL NECESSITY GUIDELINE

DEPARTMENT: Pharmacy	**DOCUMENT NAME:** Request for Medically Necessary Drug not on the PDL
PAGE: 2 of 3	**REFERENCE NUMBER:** NH.PMN.16
EFFECTIVE DATE: 09/15	**REPLACES**
RETIRED:	**REVIEWED:** 08/16, 07/17
PRODUCT TYPE: All	**REVISED:**

Approval:

agents within the same therapeutic class **or** PDL drugs that are recognized as standards of care for the treatment of the same diagnosis **OR**

B. Documented intolerance to the preferred drug(s)is considered a trial and failure; **OR**
C. Documented contraindication to the preferred drug(s) or drug interaction with preferred drug(s); **OR**
D. Documented allergy to the preferred drug(s); **OR**
E. Documented history of unacceptable or toxic side effects to preferred drug(s); **OR**
F. Documented age specific indication; **OR**
G. Documented medical co-morbidity, medical complication, or unique patient circumstances; **OR**
H. Clinically unacceptable risk with a change in therapy to the preferred agent; **OR**
I. Documented clinical history or presentation where the patient is not a candidate for any of the PDL agents for the indication

*Provided two (2) agents exist in the therapeutic category with comparable labeled indications. Noted that many PDL positioned drugs are considered first-line standards of care by governing specialty organizations and recognized under their treatment guidelines for certain conditions, even in the absence of FDA approved labeling.

Approval:

Initial Approval: 12 months or the requested length of therapy, whichever is less.
Continued Approval: 12 months.

Special Instructions
☐Varies among drug products.

nh healthy families

MEDICAL NECESSITY GUIDELINE

DEPARTMENT: Pharmacy	**DOCUMENT NAME:** Request for Medically Necessary Drug not on the PDL
PAGE: 3 of 3	**REFERENCE NUMBER:** NH.PMN.16
EFFECTIVE DATE: 09/15	**REPLACES**
RETIRED:	**REVIEWED:** 08/16, 07/17
PRODUCT TYPE: All	**REVISED:**

References: N/A

Revision Log	
Revision	**Date**
Annual Review, No Changes	08/16
Annual Review, No Changes	07/17

POLICY AND PROCEDURE APPROVAL

Pharmacy & Therapeutics Committee: Approval on file

V.P., Pharmacy Operations: Approval on file

Sr. V.P., Chief Medical Officer: Approval on file