UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Non-Preferred Drugs- IDAHO

Program	Prior Authorization
Medication	Non-Preferred Drugs
Markets in Scope	Idaho

1. Background:

Purpose: Many medically necessary drugs have very specific indications and or less costly alternatives that have documented efficacy. The formularies/PDLs of the health plans administered by UnitedHealthcare Community Plan are intended to provide the highest quality care while containing cost. The drug therapies to which this policy applies are not part of these formularies/PDLs and will be reimbursed through a prior authorization procedure.

Policy: UnitedHealthcare Community Plan requires prior authorization for the drug therapies that are assigned prior authorization status under this policy in order to promote high quality cost effective care, and to monitor utilization. This procedure enhances formulary/PDL compliance and appropriate prescribing. Eligibility for reimbursement is based upon a clinical review protocol established by the UnitedHealthcare Community Plan Pharmacy and Therapeutics Committee.

Rationale: This policy is intended to ensure that medications subject to prior authorization, including those not listed on the Plan Formulary/PDL, are utilized in accordance with FDA indications and uses found in the compendia of current literature.* This policy aims to foster cost-effective, first-line use of available formulary/PDL medications.

2. Coverage Criteria:

A. Authorization Criteria

1. A request for a non-preferred medication will be approved based on **one** of the following criteria

   a. **All** of the following:

      (1) **One** of the following:

         (a) **Both** of the following:

            i. **One** of the following:

a) History of failure to at least **one** preferred alternative as confirmed by claims history or submission of medical records. Prior trials of formulary/PDL alternative must sufficiently demonstrate that the formulary/PDL alternative is either ineffective or inappropriate at the time of the request.

-OR-

b) History of contraindication or intolerance to **one** preferred alternative (please specify contraindication or intolerance). Prior trials of formulary/PDL alternative must sufficiently demonstrate that the formulary/PDL alternative is either ineffective or inappropriate at the time of the request.

-AND-

ii. **One** of the following:

a) If the request is for a multi-source brand medication, OR a branded medication with an authorized generic, **all** of the following:

- Failure of at least 2 generic agents from a different manufacturer.
- Documented MEDWATCH form submitted to the FDA noting failure of generic agents.

-OR-

b) If the request is for a generic when there is a brand available and the brand is the preferred formulation, **one** of the following:

- The generic is being requested because of an adverse reaction, allergy or sensitivity to the brand (specify the adverse reaction, allergy, or sensitivity).
- The generic is being requested due to an incomplete response with the brand, as documented by submission of medical records.
- The generic is being requested because transition to the brand could result in destabilization of the patient.

- Special clinical circumstances exist that preclude the use of the brand equivalent of the generic medication for the patient (document special clinical circumstances).

-OR-

(b) There are no preferred formulary alternatives for the requested drug.

-AND-

(2) **One** of the following:

(a) The requested drug must be used for an FDA-approved indication.

-OR-

(b) The use of this drug is supported by information from the appropriate compendia of current literature.*

-AND-

(3) The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program.

-OR-

b. The requested medication is a behavioral health medication and **one** of the following:

(1) The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days).

-OR-

(2) The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge.

Authorization will be issued for 12 months.

*Compendia of current literature: • American Hospital Formulary Service Drug Information • National Comprehensive Cancer Network Drugs and Biologics Compendium • Thomson Micromedex DrugDex • Clinical Pharmacology • United States Pharmacopoeia-National Formulary (USP-NF)

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

Program	Program type – Non-preferred Drugs
Change Control	
Date	Change
6/2010	Criteria were taken from a previously approved Unison policy, RX06 Non PDL. Policy was reformatted. Added non-preferred behavioral health medication criteria.
3/2011	Annual Review
3/2012	Annual Review
3/2013	Annual Review
12/2015	Annual Review
10/2016	Added step to support approval of non-preferred medications with no preferred alternatives.
2/2017	Separated behavioral health into its own section. Updated policy template. Changed "Community & State" to "Community Plan" in background.
3/2017	Added multisource brand language. Removed the statement about the drug being used within manufacturer's published dosing guidelines since this is part of the quantity limit review, not the non-preferred review.
6/2018	Added language to allow for a step through fewer than three preferred alternatives if there are not three preferred alternatives available.
6/2019	Updated list of compendia of current literature.
10/2019	Updated multisource brand language to account for authorized generics.
10/2020	Annual review. Updated background and added additional clinical rules statement.
2/2021	Added review criteria for circumstances where there is a brand over generic strategy in place.
11/2021	Added review criteria for circumstances where the request is for an isomer, pro-drug, metabolite or similar active ingredient or chemical entity to a preferred medication.
2/2022	Annual review, updated language in the authorization criteria from therapeutic failure to incomplete response. Removed criteria for circumstances where the request is for an isomer, pro-drug, metabolite or similar active ingredient or chemical entity to a preferred medication.
5/2022	Updated failure, contraindication and intolerance language within policy. Updated the brand/generic language to include submission of medical records and/or documentation where necessary.
5/2023	Annual review, minor formatting changes with no change to clinical intent.

5/2024	Annual review no changes to clinical content.
5/2025	New policy specific to Idaho. Changed step through to one agent. Added state mandated language for brand requests.