UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Therapeutic Duplication

Program	Prior Authorization
Medication	Therapeutic Duplication
Issue Date	6/2022
Pharmacy and Therapeutics Approval Date	5/2025
Effective Date	06/2025

1. Background:

The following situations would result in application of the therapeutic duplication edit:

- The requested medication has been utilized concurrently with a different drug in the same therapeutic class per recent prescription claims history.
- The requested medication has been utilized concurrently in a different dosage form of the same medication per recent prescription claims history.
- The requested medication has been utilized concurrently with a different drug in a different therapeutic class per recent prescription claims history, when the two medications share the same clinical indication but lack support from evidence-based medicine.

2. Drug Classes Subject to a Therapeutic Duplication Edit

i. Drug Classes Subject to Therapeutic Duplication Edit Subtype A:
*****Both brand and generic versions of medications are subject to edit

- **Basal Insulin**
- **Respiratory Agents: Asthma and COPD**
  - INHALED CORTICOSTEROIDS
  - ICS/LABA COMBO PRODUCTS
  - LONG-ACTING BETA AGONISTS
  - LONG-ACTING MUSCARINIC ANTAGONISTS
  - LAMA/LABA COMBO PRODUCTS
- **Diabetes Agents**
  - SGLT-2 INHIBITORS
  - GLP-1 RECEPTOR AGONISTS **(Includes GLP-1s indicated for weight management, with market specific exception)
  - DPP-4 INHIBITORS
  - DPP-4-SGLT-2 COMBO PRODUCTS
- **Skeletal Muscle Relaxants**
- **Gabapentinoids**
- **NSAIDS**
- **Oral Anticoagulants**
- **Sleep Aides**

ii. Drug Classes Subject to Therapeutic Duplication Edit Subtype B:
*****Both brand and generic versions of medications are subject to edit

- **Immunomodulators**
  - IMMUNOMODULATORS (CYTOKINE & CAM ANTAGONISTS)
  - MULTIPLE SCLEROSIS IMMUNOMODULATORS
  - ANTIASTHMATIC MONOCLONAL ANTIBODIES

3. Market Applicability

Market	Basal Insulin	Diabetes Agents GLP-1** DPP-4 SGLT-2	Respir-atory Agents	Immuno-modulators	Skeletal Muscle Relaxants	Gaba-penti-noids	NSAIDS
Arizona	Core	Core	Core	Core	Core	Core	Core
Colorado	Core	Core	Core	Core	Core	Core	Core
Florida	See FL-specific policy	See FL-specific policy					
Hawaii	Core	Core	Core	Core	Core	Core	Core
Idaho							Core
Indiana	Core	Core	Core	Core	Core	Core	Core
Kansas	Core	Core	Core	Core	Core	Core	Core
Maryland	Core	Core	Core	Core	Core		Core
Michigan	Core	Core (Does not include wt mgmt GLP1)	Core	Core	Core		Core
Minnesota	Core	Core	Core	Core	Core	Core	Core
Nebraska	Core	Core	Core	Core	Core	Core	Core
Nevada	Core	Core	Core	Core	Core	Core	Core
New Jersey	Core	Core	Core	Core	Core	Core	Core
New Mexico	Core	Core	Core	Core	Core	Core	Core
New York-CHIP, EPP	Core	Core	Core	Core	Core	Core	Core
North Carolina	Core	Core	Core	Core	Core	Core	Core
PA-M							
PA-CHIP	Core	Core	Core	Core	Core	Core	Core
Rhode Island	Core	Core	Core	Core	Core	Core	Core
Texas	Core	Core (Except	Core		Core	Core	Core

		GLP-1 + GLP-1)					
Virginia	Core	Core	Core	Core	Core	Core	Core
Washington	Core	Core	Core	Core	Core (Except carisoprodol products- see state guideline)	Core	Core

**(Includes GLP-1s indicated for weight management, with market specific exception)

Market	Oral Anti-coagulants	Sleep Aides
Arizona		
Colorado	Core	Core
Florida		
Hawaii	Core	Core
Idaho		
Indiana	Core	
Kansas	Core	Core
Maryland	Core	
Michigan	Core	Core
Minnesota	Core	Core
Nebraska	Core	Core
Nevada	Core	Core
New Jersey	Core	Core
New Mexico	Core	Core
New York-CHIP, EPP	Core	Core
North Carolina	Core	Core
PA-M		
PA-CHIP	Core	Core
Rhode Island	Core	Core
Texas	Core	Core
Virginia	Core	Core
Washington	Core	Core

The applicability in the above grid speaks only to the alignment with core therapeutic duplication edits, it does not account for any state-defined therapeutic duplication edits.

4. Coverage Criteria:

i. Therapeutic Duplication criteria

Subtype A. The requested medication that is subject to the therapeutic duplication edit will be approved based on **one** of the following criteria:

1. The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

-OR-

2. **All** of the following
   a. The requested medication combination is supported by information from the appropriate compendia of current literature. *
   b. The drug combination is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program.
   c. The provider attests that they are aware that the patient is using duplicate therapy
   d. Special clinical circumstances exist that necessitate the need for duplicate therapy (document special circumstances)
   e. Provider attests that the necessity for continued concomitant therapy and safety will be periodically assessed

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)

Subtype B. The requested medication that is subject to the therapeutic duplication edit will be approved based on the following criteria:

1. The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

Authorization will be issued for 12 months

5. 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	Prior Authorization– Therapeutic Duplication
Change Control	
6/2022	New Program for state market guidelines.
9/2022	Removed core non-preferred medication review criteria from this document. Each state market has their own pre-existing non-preferred criteria already embedded in their unique guidelines.
3/2023	Redesigned Therapeutic Duplication Administrative Policy. Removed drug names, refer to drug classes and criteria as designed. Added market applicability grid supplied by DUR.
5/2023	Moved Florida to its own policy. Added Mississippi note and updated table note.
6/2023	Added additional drug classes with market applicability supplied by DUR team. Washington exception, for carisoprodol products see state carisoprodol guideline which incorporates TD DUR. Nebraska to be determined.
7/2023	Nebraska DUR and policy approved for 9/1 go-live.
11/2023	Additional drug classes added with market applicability supplied by DUR team.
12/2023	Removed PPIs from DUPLIMIT service at this time per DUR team.
1/2024	Updated Kansas market applicability for Sleep Aides and Oral Anticoagulants.
2/2024	Updated Kansas market applicability, they will now be in scope for all categories listed.
5/2024	Added New Mexico, new market as of 7/1, all DUPLIMIT services will apply.
5/2024	Expanding North Carolina DUPLIMIT service to include Basal Insulin, Diabetes Agents, Respiratory Agents, Immunomodulators, Skeletal Muscle Relaxing Agents, Gabapentinoids, and NSAIDS. DUPLIMIT service already in place on Oral Anticoagulants, Sleep Aides, and Weight Management GLP-1. Mississippi market full carve out 7/1.
11/2024	The Therapeutic Duplication hard edit for Weight Management GLP-1 + Weight Management GLP-1 and Weight Management GLP-1 + Diabetic GLP-1 will be removed from the core CDUR program. Weight Management GLP-1s will be added to the DUPLIMIT service with all other GLP-1s to streamline the drug class on one CDUR service.
12/2024	Adding Washington into scope for core service on Basal Insulin, Diabetes Agents, and Respiratory agents for 2/3/25. Adding Virginia into scope for core service on Basal Insulin, Diabetes Agents, Respiratory agents, and Immunomodulators.
5/2025	Added Idaho in scope for NSAID therapeutic duplication edit.