MEDICATION POLICY:

Medical Necessity

Generic Name: N/A

Therapeutic Class or Brand Name: N/A

Applicable Drugs (if Therapeutic Class): N/A

Preferred: Formulary products

Non-preferred: Non-formulary products

Date of Origin: 9/28/21

Date Last Reviewed / Revised: 6/10/2025

AUTHORIZATION CRITERIA

(A medical necessity review is required on certain medications covered under the pharmacy and medical benefit. This includes, but is not limited to, non-formulary exception requests. Medications without specific medication policy criteria available may be considered for medical necessity override when all criteria I through VI are met)

I. Medication is justified by prescribing physician or other appropriate healthcare provider as reasonable, necessary, and appropriate to treat a condition, illness, disease, or injury based on evidence-based standards of medical practice and criteria A and B are met:

   A. Includes documentation of why treatment with the specific non-formulary medication is necessary.

   B. Requested medication is used for an FDA-approved indication, or use is supported by current clinical practice guidelines.

II. Medication meets plan-wide acknowledged criteria, including but not limited to health plan criteria and benefit language.

   A. When a non-formulary medication is designated in the plan document as not covered, this is a benefit denial.

III. Medication is not primarily for the convenience of the patient, family, or provider.

IV. Physician evaluation and charted documentation indicating one or more of the following criteria A through C are met:

   A. Trial and failure of formulary and/or lower cost alternative(s) within the previous 120 days and with a duration of ≥ 90 days.

   B. Clinically significant intolerance/adverse events to ALL formulary and/or lower cost alternative(s),

   C. Clinically significant contraindication and/or intolerance to ALL formulary and/or lower cost alternative(s) pertaining to patient's diagnosis, medication conditions or other medication therapy.

V. For Brand Name medication requests, documentation of both of the following:

   A. Treatment failure on cost-effective within-class alternatives or cost-effective therapeutically superior or therapeutically equivalent alternatives to the requested brand product, including but not limited to generics.

B. Explanation of why treatment with the specific branded product is necessary.

VI. The existing formulary policy applies to any drug granted a medical necessity override. This includes, but is not limited to, policy pertaining to drug classes that require step therapy (ST), drugs that require clinical prior authorization (PA), drugs designated as Formulary Shield, and specialty inclusion criteria.

Exclusion Criteria

- N/A

Other Criteria for Brand Medication Requests

- Multi-source specialty brand products with available generic, therapeutic, or biosimilar alternatives may not be considered.
- For extended-release non-formulary products, where there are no extended-release formulary equivalents, an adequate trial of the short-acting formulary and/or lower-cost alternative is required.
- Many extended-release branded products do not have extended-release generic equivalents. In these cases, an adequate trial of the short-acting generic product is required.
- Some brand-name dosage forms may not have the same dosage form available in a generic therapeutic equivalent. In these cases, an adequate trial of the other available dosage forms of the generic therapeutic equivalent is required unless documentation shows the member is unable to consume the dosage form (e.g., liquid formulation for infants/children).
- Patient complaints of lack of efficacy are not acceptable reasons for failure such as "Client said", "client reports", "doesn't work", or "causes nausea".

Quantity / Days Supply Restrictions

- Quantity/Days supply restrictions may apply.

Approval Length

- **Authorization:** Up to 12 months.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing that current prior authorization criteria are met and that the medication is effective.

Appendix

N/A

References

1. N/A

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.