Administrative Policy Statement
INDIANA MEDICAID

Policy Name	Policy Number	Date Effective
Medical Necessity for Non-Preferred Medications	PAD-0003-IN-MCD	03/15/2023

Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care ser9 (c)3.5 (al)-5.9 (pol)-5op pol These services meet the

t alternative, and are not provided mainly for the
also include those services defined in any Evidence of
ember Handbooks, and/or other policies and procedures.

4.6G)-21.4 (313 Td [-Administrative ent def (l-5.9 a(a)14.7 (Policy Statement (and the plan 1.4 (li)9 (ned g(313 Td a,)5.4 (Sl)9.and u,)5.4 (en)14.7 (c))-9.6 (e)14.7d (r)0.7 m
contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling c

make the determination.

Table of Contents

Administrative Policy Statement 1
A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 2
E. Conditions of Coverage 4
F. Related Policies/Rules 4
G. Review/Revision History 4
H. References 4

A. Subject

CareSource uses a preferred medication list that is established, reviewed and approved by the CareSource Pharmacy and Therapeutics (P&T) Committee and the regulatory bodies in each state in which CareSource functions. The preferred is reviewed routinely, and medication can be removed from the preferred drug list when the brand name becomes generically available or when it is no longer cost-effective compared to other existing or newer products.

For new drugs or new indications for drugs, the P&T Committee generally reviews for preferred status decision after 180 days from market release. CareSource will follow the guidance of the state Medicaid programs in the states that it services to enforce clinically appropriate lower cost agents as first line therapy for our preferred agents.

B. Background

The intent of CareSource Pharmacy Policy Statements is to encourage appropriate selection of members for therapy according to product labeling, clinical guidelines, and/or clinical studies as well as to encourage use of preferred agents. The CareSource Pharmacy Policy Statement is a guideline for determining health care coverage for our members with benefit plans covering prescription drugs. Pharmacy Policy Statements are written on selected prescription drugs requiring prior authorization or step therapy. The Pharmacy Policy Statement is used as a tool to be interpreted in conjunction with the member's specific benefit plan.

NOTE: The Introduction section is for your general knowledge and is not to be construed as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals and is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider can also be a place where medical care is

treatment. The pharmacist reviewer may also use clinical judgement to determine a sufficient duration of treatment.

- The member's medication trials and adherence are determined by review of pharmacy claim data over preceding 12 months or as reported in chart notes. Additional information may be requested on a case-by-case basis to complete the clinical review.
- All other uses of Non-Preferred medications are considered experimental/investigational; therefore, will follow CareSource's Medical Necessity –O ff Label policy.
- Any request for a non-preferred branded medication when a generic is available must follow CareSource's Medical Necessity for DAW policy.
- Requests for members less than 21 years old are reviewed for coverage for Early and Periodic Screening, Diagnosis, and Treatment (ESPDT) on a case-by-case basis in addition to the criteria above

E. Conditions of Coverage

As above.

F. Related Policies/Rules

Medical Necessity for DAW

Medical Necessity – Off Label

G. Review/Revision History

DATES		ACTION
Date Issued	12/06/2013	
Date Revised	08/01/2020	Policy copied to a new template. The diagnostic requirement and drug trial requirement revised. Added durations for initial authorization and reauthorization. Added reauthorization criteria.
	11/08/2022	Section D part III: Added complex/rare disease states. Changed renewal duration from up to 6 months to up to 12 months.
	2/24/2023	Added note on EPSDT.
Date Effective	03/15/2023	
Date Archived		

H. References

Not applicable.

This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

The Administrative Policy Stateme nt detailed above has r eceived due consideration as defined in the Administrative Policy Stateme nt Policy and is a pp rove d.