

Administrative Policy Statement GEORGIA MEDICAID

Policy Name		Policy Number	Date Effective
Medical Necessity for Multi-Source Brands		PAD-0005-GA-MCD	TBD
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 are based upon generally accepted medical practices in light of Conditions at the time of treatment. Medically Necessary Services are those that are:

- i. Required to correct or ameliorate a defect, physical or mental illness, or a Condition
 - ii. Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member's medical Condition
 - iii. Compatible with the standards of acceptable medical practice
 - iv. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
 - v. Not provided solely for the convenience of the Member or the convenience of the Health Provider
 - vi. Not primarily custodial care unless custodial care is a Covered Service or benefit under the Member's evidence of coverage
- Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available

Medically necessary services for Mental Health or Substance Abuse Disorder include a service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is in accordance with the generally accepted standards of mental health or substance use disorder care, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

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A. Subject

CareSource uses clinical drug policies that are established, reviewed and approved by the CareSource Pharmacy and Therapeutics (P&T) Committee and the regulatory bodies in each state in which CareSource functions. Policies are reviewed routinely, and a generic medication can be required 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 policy updates 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.

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 encourage the use of formulary 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 given, like a hospital, clinic or lab. This policy informs providers about when a service may be covered.*

C. Definitions

- **Allergic Reaction:** an allergic reaction, as defined by the American Academy of Allergy Asthma & Immunology, occurs when the immune system overreacts to a harmless substance. Types of allergic symptoms to medications range from skin rashes or hives, itching, respiratory problems, and swelling to anaphylaxis. All medications have the potential to cause side effects, but only about 5 to 10% of adverse reactions to drugs are allergic.¹
- **Clinical Judgment:** decisions made within the scope of the expertise of a pharmacist following the review of subjective and objective medical data for a member. A pharmacist can use Clinical Judgment for a benefit determination. If the request is outside the scope of a pharmacist's expertise, a benefit determination will be made in collaboration with a medical director.
- **Multi-Source Brand:** brand name medication sold or marketed by multiple manufacturers and has therapeutically equivalent generics available.
- **Drug:** a medication or substance which induces a physiologic effect on the body of a member (i.e., medication, agent, drug therapy, treatment, product, biosimilar drugs, etc.).
- **Formulary Drug List:** a list of prescription drugs which includes a group of selected generic and brand-name drugs which are covered by CareSource.
- **Non-Formulary Drug:** a drug not on the Formulary Drug List.
- **Medically Necessary Services (includes concepts of Medically Necessary and Medical Necessity):** Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary Services are those that are:
 - i. Required to correct or ameliorate a defect, physical or mental illness, or a Condition

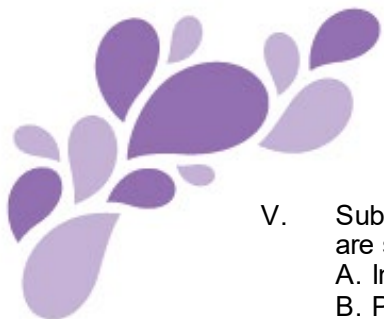


- ii. Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member's medical Condition
 - iii. Compatible with the standards of acceptable medical practice
 - iv. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
 - v. Not provided solely for the convenience of the Member or the convenience of the Health Provider
 - vi. Not primarily custodial care unless custodial care is a Covered Service or benefit under the Member's evidence of coverage
 - vii. Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available
- **Medically Necessary Services (Mental Health or Substance Use Disorder):** The treatment of a mental health or substance use disorder, service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:
 - i. In accordance with the generally accepted standards of mental health or substance use disorder care;
 - ii. Clinically appropriate in terms of type, frequency, extent, site, and duration; and
 - iii. Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

D. Policy

CareSource will approve the use of multi-source brand medications and consider their use as medically necessary when the following criteria have been met. This policy will not supersede drug-specific criteria developed and approved by the CareSource P&T Committee nor drug or therapeutic category benefit exclusions. Prior authorization requests should be submitted for each multi-source brand request with chart notes and documentation supporting medical necessity.

- I. Member has tried and failed both of the following:
 - A. Two generic manufacturers of the requested brand name medication at an adequate dose for an adequate duration (information must be provided regarding the treatment target or goal that was inadequately met) AND
 - B. All formulary alternatives within the same drug class as the requested brand name medication that have an FDA-approved indication to treat the member's condition OR
- II. The member had a serious adverse event with the generic version(s) and the prescriber has provided a copy and confirmation of a MedWatch form submission to the FDA documenting the adverse outcome experienced by the member that includes one of the following (Note: The MedWatch form is available at <https://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf>):
 - A. Was life threatening
 - B. Required hospitalization
 - C. Caused disability or permanent damage
 - D. Required intervention to prevent permanent impairment/damage OR
- III. Member has a history of allergic reaction to an inactive ingredient in the generic product and the prescriber has documented the inactive ingredient, the reaction (dates and clinical details), and the manufacturer of the generic product.
- IV. Initial approval duration for multi-source brand product request: Up to 6 months



- V. Subsequent approvals may be renewed for up to 12-month durations, such that chart notes are submitted with the request which clearly document all of the following:
- A. Initial criteria were previously met
 - B. Positive clinical response to therapy with the requested brand name product
 - C. No toxicities or serious adverse reactions have been experienced with the brand name product

All other uses of Brand Name Medications are considered not medically necessary.

Requests will not be approved for treatment of non-FDA approved diagnoses or conditions not supported by compendia evidence. Please refer to the Medical Necessity – Off-Label policy.

Notes:

- If the requested medication has a Medication Specific Policy, the member will need to meet those requirements in addition to the multi-source brand policy.
- The start date and duration of the trial must be provided.
- There must be paid claims if the member was enrolled with CareSource when a trial of a medication occurred.
- Documented diagnoses must be confirmed by portions of the individual's medical record which need to be supplied with prior authorization requests. These medical records may include, but are not limited to test reports, chart notes from provider's office, or hospital admission notes.
- Requests for members less than 21 years old are reviewed for coverage for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) on a case-by-case basis in addition to the criteria above.

Refer to the product package insert for dosing, administration and safety guidelines.

E. Conditions of Coverage

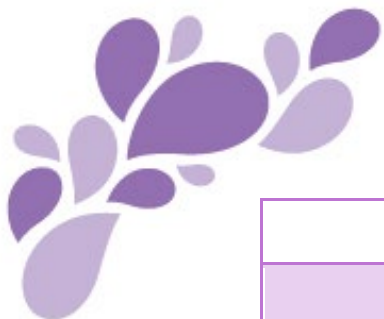
As above.

F. Related Policies/Rules

Medical Necessity – Off Label

G. Review/Revision History

DATES		ACTION
Date Issued	08/01/2018	
Date Revised	08/01/2020	Reviewed content, transferred to new template, added note about non-coverage of off-label/non-supported use.
	10/28/2022	Section D, part I: Changed bullet A to address inefficacy rather than adverse events, since adverse events are addressed in part II. Created criteria to specify durations of approval and requirements for re-authorization. Made grammatical/wording changes for readability.
	3/1/2023	Added note on EPSDT.
	5/21/2024	Annual review, no updates



	8/27/2024	Updated policy to “Medical Necessity for Multi-source Brands,” removed references to formulary.
	2/12/2026	Updated medical necessity definition to align with O.C.G.A. 33-21A-13.
Date Effective	TBD	
Date Archived		

H. References

1. deShazo RD, Kemp SF. Allergic reactions to drugs and biologic agents. JAMA. 1997;278:1895–906.
2. Official Code of Georgia Annotated. § 33-21A-13.

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 Statement detailed above has received due consideration as defined in the Administrative Policy Statement Policy and is approved.