Administrative Policy Statement
NEVADA MEDICAID

Policy Name	Policy Number	Date Effective
Medical Necessity for Non-Preferred Drugs	PAD-0004-NV-MCD	01/01/2026

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 services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or 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.

Table of Contents

A. Subject

CareSource uses a Preferred Drug List (PDL) that is established, reviewed and approved by the CareSource Pharmacy and Therapeutics (P&T) Committee. The PDL is subject to Statewide Uniform Preferred Drug List requirements when applicable. The PDL is reviewed routinely. Where contractually permitted, drugs can be removed from the PDL 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 CareSource P&T Committee generally reviews for PDL status decision within 180 days from market release. CareSource adheres to all contractual and regulatory requirements applicable to a given market.

B. Background

The intent of CareSource Pharmacy Administrative Policy Statements is to encourage appropriate selection of drug therapy for members according to product labeling, clinical guidelines, and/or clinical studies as well as to encourage use of preferred agents. The CareSource Pharmacy Administrative Policy Statement is a guideline for determining health care coverage for our members with benefit plans covering prescription drugs. Pharmacy Administrative Policy Statements are written on selected drug coverage scenarios. The Pharmacy Administrative 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

- **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 for an exception request for a Non-Preferred Drug. If the request is outside the scope of a pharmacist's expertise, a benefit determination will be made in collaboration with a medical director.
- **Covered 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.). Drug coverage is defined by law or contract. Covered drugs have a path to medical necessity while non-covered drugs are benefit exclusions.
- **Preferred Drug List:** A list of brand name and generic drugs, as well as other pharmaceutical products, that are available to CareSource members when prescribed by a physician or other duly licensed healthcare provider. The PDL includes drugs that are eligible to be covered provided they are medically necessary; these drugs may be subject to Utilization Management strategies such as step therapy and quantity limits. The CareSource PDL includes drugs that are included on the Statewide Uniform Preferred Drug List and managed by the Nevada Silver State Scripts Board (SSSB).
- **Medical Necessity:** Describes a health care service or product that a prudent provider would provide to a patient to prevent, diagnose, or treat an illness, injury, or disease, or any symptoms thereof, that are necessary and:
    - Provided in accordance with generally accepted standards of medical practice;

  - Clinical appropriate with regard to type, frequency, extent, location, and duration;
  - Not primarily provided for the convenience of the patient, physician, or other provider of health care;
  - Required to improve a specific health condition of a member or to preserve the existing state of health of the member including allowing a member to achieve age-appropriate growth and development; and
  - The most clinically appropriate level of health care that may be safely provided to the member.
- **Neutral Drug:** Refers to any brand name or generic drug that is not subject to management by the Nevada Silver State Scripts Board (SSSB) either by inclusion on the Statewide Uniform Preferred Drug List, by publication of SSSB drug utilization review criteria, or by other contractual or regulatory designation. Neutral drugs are managed by the CareSource Pharmacy & Therapeutics Committee.
- **Non-Preferred Drug or Product:** A drug or pharmaceutical product that is not included on the PDL or is included on the PDL with a designation of "Non-Preferred" but is eligible for coverage by CareSource when a request by a member or provider is received, undergoes review for clinical appropriateness, and is approved.
- **Pharmacy & Therapeutics (P&T) Committee** – The final decision-making body for the CareSource Pharmacy Preferred Drug List and Utilization Management strategies. The P&T Committee evaluates the clinical efficacy and safety of products and approves all Preferred/Non-Preferred designations for Neutral Drugs.
- **Psychiatric Condition** – A mental disorder for which criteria are prescribed in the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psyciatric Association (APA).
- **Statewide Uniform Preferred Drug List (SUPDL)** – A list of brand name and generic drugs, as well as other pharmaceutical products, that have been designated as Preferred or Non-Preferred by the Nevada Silver State Scripts Board (SSSB) and are available to CareSource members according to the NV SSSB PDL designation.
- **Thereapeutic failure** – Failure to achieve therapeutic goals after the member has used a stable dose of the drug for up to 90 days or a duration specified in treatment guidelines or package insert as a sufficient duration to observe benefit from treatment. The pharmacist reviewer may also use clinical judgement to determine a sufficient duration of treatment.

D. Policy

CareSource will approve the use of Non-Preferred drugs and consider their use to be Medically Necessary when the criteria listed below have been met. This policy will not supersede drug-specific criteria developed and approved by either the CareSource P&T Committee or the Nevada Sivler State Scripts Board (SSSB) nor drug or therapeutic category benefit exclusions. Prior authorization requests should be submitted for each Non-Preferred drug with chart notes and documentation supporting Medical Necessity.

Initial Criteria:

I. The member has an allergy to ALL preferred drugs within the same drug class; OR
II. The member has a contraindication to or drug-to-drug interaction with ALL preferred drugs within the same drug class; OR
III. The member has a history of unacceptable/toxic side effects to ALL preferred drugs within the same drug class; OR
IV. The member has had a therapeutic failure meeting one of the following:
    a. At least TWO preferred drugs within the same drug class, OR

b. If there are not two preferred drugs within the same drug class, therapeutic failure of ONE preferred drug, OR
c. If the request is for a drug in one of the following therapeutic categories, a therapeutic failure of ONE preferred drug:
    i. Atypical antipsychotic drug,
    ii. Typical antpsychotic drug,
    iii. Anticonvulsant drug,
    iv. Antidiabetic drug, OR

V. The requested non-preferred drug has a unique indication that is not shared by a preferred drug in the same drug class. The requested indication is supported by peer reviewed literature or is an FDA-approved indication.

Initial approval is limited to the length of request but no more than 6 months.

Initial Criteria – Psychotropic, Antidepressant Medications

I. The request constitutes continuity of care for a psychotropic or antidepressant drug defined as the member having been discharged from an institution on a Non-Preferred psychotropic and/or Non-Preferred antidepressant drug; OR
II. The drug is being prescribed for a psychiatric condition and ALL of the following criteria have been met:
    a. The drug has been approved by the FDA with indications for the psychiatric condition of the member OR the use of the drug to treat that psychiatric condition is supported by medical or scientific evidence, and the prescriber provides supporting clinical documentation demonstrating the approved diagnosis or evidence for use; AND
    b. The prescriber of the drug is one of the following:
        i. A psychiatrist;
        ii. A physician assistant under the supervision of a psychiatrist;
        iii. An APRN who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or
        iv. A primary care provider that is providing care to a member in consultation with one of the providers listed above if the closest provider type listed above is located 60 miles or more from the member's residence; AND
    c. The prescriber believes based on the medical history of the member or reasonably expects each preferred drug within the same drug class to be ineffective at treating the psychiatric condition AND the prescriber provides supporting clinical documentation demonstrating the reasoning for use of the drug.

Initial approval is limited to the length of request but no more than 6 months.

Renewal Criteria:

I. Chart notes have been provided showing the member has had a positive response to therapy; AND
II. The requested use and dosage remain consistent with FDA-approved prescribing information in the drug package insert or is supported by medical or scientific evidence as described above.

Renewal approval is limited to the length of request but no more than 12 months.

Notes:

- 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 Neutral medications are considered experimental/investigational; therefore, will follow CareSource's Medical Necessity – Off Label policy.
- Any request for a Neutral branded medication when a generic is available must follow CareSource's Medical Necessity for DAW policy.

E. Conditions of Coverage

As above.

F. Related Policies/Rules

Medical Necessity for Multi-Source Brands

Medical Necessity – Off Label

G. Review/Revision History

	DATES	ACTION
Date Issued	**01/01/2026**	
Date Revised	**10/22/2025**	Policy created
Date Effective	**01/01/2026**	
Date Archived		

H. References

NRS 695G.055

Medicaid Services Manual – Chapter 1200; Section 1203.1

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.

NV-MED-P-4165902