



Administrative Policy Statement OHIO MEDICAID

Policy Name	Policy Number	Date Effective
Multi-Ingredient Compound Policy	PAD-0039-OH-MCD	04/01/2021
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

Administrative Policy Statement.....	1
A. Subject.....	2
B. Background.....	2
C. Definitions	2
D. Policy	2
E. Conditions of Coverage.....	3
F. Related Policies/Rules	3
G. Review/Revision History	4
H. References	4



A. Subject

Pharmacy – Multi-ingredient Compound Policy

B. Background

Pharmacy compounding is defined as the combining, mixing or altering of ingredients to create a customized medication for a specific patient. Compounded medications are made based on a practitioner's prescription in which individual ingredients are mixed together in the exact strength and dosage form required by the patient.

C. Definitions

- **Multi-ingredient Compound** – a product containing two or more ingredients that is not FDA approved and is prepared upon the order of a physician for a patient.

D. Policy

All **multi-ingredient compounds** (except topical pain compounds) will be considered medically necessary when **ALL** of the following criteria are met:

- I. The primary active ingredients in the compound are approved by the FDA for the indication AND
- II. The active ingredients are prescribed in therapeutic amounts based on FDA approved indications AND
- III. The compound contains only one active ingredient per any specific therapeutic class of drugs as defined by First Data Bank AND
- IV. If a compound is similar to a commercially available product but differs in dosage, dosage form, or inert ingredient (such as flavoring, dye, or preservative), chart notes are required from the prescriber supporting the need for the compound (i.e. documented difficulty or inability to swallow oral dosage forms, documented allergies to inactive ingredients) AND
- V. If any ingredient in the compound, active or inactive, otherwise requires prior authorization, the member must meet criteria established for medical necessity for that ingredient AND
- VI. If any active ingredient in the compound is not FDA approved for the requested indication, age, or route of administration, must have evidence from TWO published studies from major scientific or medical peer-reviewed journals to support the use of the compound as safe and effective AND
- VII. The member has tried and failed a trial at least 3 preferred medications (if available) that can be used to treat the member's condition. Trial dates must be included with prior authorization request AND
- VIII. Compound will not be covered under the following circumstances:
 - a. The compound is being used for an excluded benefit (e.g., cosmetic, obesity, sexual dysfunction, infertility, etc.)
 - b. The compound contains ingredients that were withdrawn or removed from the market for safety reasons
 - c. The compound is for a product that is commercially available
 - d. The compound is for purposes of convenience only.



Topical pain compounds will be considered medically necessary when **ALL** of the following criteria are met:

- I. Member must have a diagnosis of chronic moderate to severe pain associated with neuropathic pain or nociceptive pain AND
- II. Member must have tried at least 3 of the following drugs from different groups for at least 30 days each:
 - a. Non-opioid oral medications or a documented contraindication
 - b. Diclofenac sodium gel 1% or over-the-counter (OTC) Voltaren gel
 - c. Topical lidocaine (e.g., lidocaine cream 3%, 4%, lidocaine patch 4%)
 - d. Topical capsaicin AND
- III. The compound contains no more than 1 active ingredient per any specific drug class as defined by First Data Bank AND
- IV. The compound contains no more than 3 drug classes for active ingredients AND
- V. The compound does NOT contain any controlled substances AND
- VI. The active ingredients must be FDA approved or compendia supported for topical use and for the pain indication.

Reauthorization:

Pain compound:

- Member must have documented improvement of pain supported by chart notes (defined as improvement of at least 3 points on a 0 to 10 point pain scale)

All other compounds:

- Evidence of effectiveness and safety for compound must be documented in chart notes for continuation of approval.

Additional notes:

- Reimbursement will not be provided for additives such as flavorings, dyes, or preservatives.
- Requests resulting from a drug shortage will be considered on a case-by-case basis.

E. Conditions of Coverage

HCPCS
CPT

AUTHORIZATION PERIOD

Initial approval: 3 months or prescriber's requested length of therapy (if shorter than 3 months)

Reauthorization: 12 months

F. Related Policies/Rules

Medical Necessity for Non-Formulary / Non-Preferred Medications Policy

Medical Necessity - Off Label



G. Review/Revision History

DATES		ACTION
Date Issued	07/01/2016	Initial Release to P&P Committee
Date Revised	08/01/2016	2016 Annual Review with No Changes
	06/01/2017	2017 Annual Review with No Changes
	02/01/2018	Updated criteria to limit compounds to having one ingredient per drug class and 30 day trial of preferred medications
	08/04/2020	Updated criteria to include requirement of 2 published studies for off-label requests, reauth criteria, approval durations. Added separate criteria set for pain compounds. Revised trial requirement to be 3 preferred medications. Changed MediSpan to First Data Bank. Removed "not medically necessary" section under Additional notes.
Date Effective	04/01/2021	
Date Archived		

H. References

N/A

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.