



ADMINISTRATIVE POLICY STATEMENT

MI Coordinated Health

Policy Name & Number	Date Effective
Medicaid-Covered Pharmacy Product Reviews-AD-11422	01/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates 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 CareSource and its affiliates 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Medicaid-Covered Pharmacy Product Reviews

B. Background

MI Coordinated Health (HMO D-SNP) covers specific Michigan Medicaid-covered drugs and products that are not covered by Medicare Part D through the member’s MI Coordinated Health Medicaid benefit. These Medicaid-covered products are listed on the *Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members* list.

Plans must have a process to approve physician’s requests to prescribe any medically appropriate drug vitamin or supplement that is covered on the *Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members* list. Some of these products (i.e., over-the-counter (OTC) products and certain non-Part D drugs) are covered without restrictions. Some of these products require prior authorization in alignment with the Michigan Medicaid Fee-for-Service Clinical and PDL Criteria. Products that are not on the *Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members* list may not have product-specific review criteria but still require a medical necessity review.

HAP CareSource, in partnership with our Pharmacy Benefit Manager, Express Scripts, will review these products per the policy below upon prior authorization request.

C. Definitions

Hierarchical Ingredient Code List – unique primary active ingredient or combination of active ingredients

D. Policy

I. For products on the *Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members* list with requirements to align with Michigan Medicaid Clinical and PDL Criteria, review is based on the product-specific criteria in the current Criteria.

II. For products that are not on the *Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members* list, approval will be provided if the following criteria are met:

- A. Trial of at least three preferred alternatives within the same Hierarchical Ingredient Code List or Specific Therapeutic Class; AND
- B. Submission of two peer-reviewed medical articles citing efficacy and safety of the drug or product.

E. Conditions of Coverage

A. For products on the *Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members* list with requirements to align with Michigan Medicaid Clinical and PDL Criteria, the duration of authorization is defined in the Criteria (initial request or renewal request).

B. For products that are not on the *Michigan Medicaid Part D Excluded Products Covered for Dual Eligible Members* list, if approval is warranted, authorization will be placed for 1 year.

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATE	ACTION
Date Effective	01/01/2026	

Date Archived		
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H. References

N/A

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