



MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
03/06/2012	11/03/2016	12/01/2015
Policy Name	Policy Number	
Medical Necessity for Physician Dispense as Written (DAW) Requests	Rx-0008	

Medical 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.

Medical 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 Medical Policy Statement. If there is a conflict between the Medical 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.

For Medicare plans please reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

A. SUBJECT

Medical Necessity for Physician Dispense as Written (DAW) Requests

B. BACKGROUND

CareSource uses a preferred drug list (Formulary) in the states that it services a Medicaid population. The formulary and the preferred products have been approved by the CareSource Pharmacy and Therapeutics (P & T) Committee and the regulatory bodies in each state if required.

C. DEFINITIONS

N/A

D. POLICY

- I. CareSource will review and approve requests for brand name medications where the prescribing physician has requested "Dispense as Written" or "DAW" and consider its use as medically necessary when the following criteria have been met. This policy is not intended to supersede exclusions or drug-specific criteria developed and approved by the CareSource P&T.
- II. CareSource requires the use of FDA approved generic equivalent medications when available; consideration will be given to using a brand-name medication in the following circumstances:
 - A. Member has tried an FDA approved generic equivalent to the requested brand medication, made by two different manufacturers (if available), for up to 90 days or otherwise stated on our desk reference the User Friendly Formulary (UFF)
AND



- B. Objective data, including but not limited to laboratory results, demonstrating that the generic was not effective is submitted
OR
- C. Chart notes that document the lack of effectiveness by stating the specific negative outcomes are submitted
OR
- D. The member has a genuine allergic reaction to an INACTIVE ingredient in the generic agent(s). Allergic reactions must be clearly documented in the member's medical record

Note: GI Upset or irritation is not generally considered an allergy or failed treatment. Members should be referred to their physician or pharmacist for advice on dose adjustment, and/or other options to reduce GI upset/irritation. Common documented side effects attributed to the drug (e.g., headache, nausea, blurred vision, fatigue, muscle aches, etc.) are not considered an allergy and would be expected to occur at the same level in both the generic and brand agent.

Note: Medications that are being used for the treatment of epilepsy or seizure disorder will be allowed to continue on a brand name medication so long as the member has been established on the brand name medication for at least 60 days.

For Medicare Plan members, reference the Applicable National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Compliance with NCDs and LCDs is required where applicable.

CONDITIONS OF COVERAGE

QUANTITY LIMITATIONS

DATA REQUIRED ON REQUEST Diagnosis, Treatment Failures

HCPCS

CPT

AUTHORIZATION PERIOD

Approved authorizations are designated an appropriate authorization period. Continued treatment may be considered when the member has shown biological response to treatment. **ALL** authorizations are subject to continued eligibility.

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 03/06/2012
Date Reviewed: 03/06/2012, 06/06/2013, 11/03/2014, 12/01/2015
Date Revised: 06/06/2013 – Grammatical errors fixed and removal of technology in reference to P&T committee
 11/03/2014 – Formatting updates

G. REFERENCES

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