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Non-Preferred Drugs - Arizona 2

Prior Authorization Guideline

Guideline ID	GL-104403
Guideline Name	Non-Preferred Drugs - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD) • Medicaid - Arizona SP (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/4/2022

1 . Criteria

Product Name: Non-Preferred Drugs	
Approval Length	12 months*
Guideline Type	Administrative

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

- If there are at least three preferred alternatives, history of trial per member's pharmacy claims resulting in a therapeutic failure, contraindication, or intolerance to at least THREE preferred alternatives (Prior trials of formulary/preferred drug list (PDL)

alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request)*

- If there are fewer than three preferred alternatives, the patient must have a history of trial per member's pharmacy claims resulting in a therapeutic failure, contraindication, or intolerance to ALL of the preferred products (Prior trials of formulary/preferred drug list (PDL) alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request)*
- There are no preferred formulary alternatives for the requested drug*

AND

1.2 If the request is for a multi-source brand medication (i.e., MSC O) ONE of the following:

1.2.1 BOTH of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to the generic and the prescriber must attest to submitting the FDA MedWatch Form for allergic reactions to the medications.
- If there are generic product(s), the member has tried at least three (if available)

OR

1.2.2 ONE of the following:

- The brand is being requested due to a therapeutic failure with the generic (please provide reason for therapeutic failure).
- The brand is being requested because transition to the generic could result in destabilization of the patient (rationale must be provided)
- Special clinical circumstances exist that preclude the use of the generic equivalent of the multi-source brand medication for the patient (rationale must be provided)

AND

1.3 ONE of the following:

1.3.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication.

OR

1.3.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- The requested drug must be used for a Food and Drug Administration (FDA)-approved indication.
- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

1.4 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program**

OR

2 - If the requested medication is a behavioral health medication, ONE of the following:

- The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days).
- The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge.

Notes	*Anti-infectives: Approve for the requested time frame, or if duration is not specified approve the request for 30 days. *Controlled Substances shall be approved for the requested time. If th ere is not a requested time period and it is not clear in the directions, approve for one time only. *Other medications: Approved for the requested time frame, or if durat ion is not specified, approve for 12 months.

	* For Non-Preferred Generics (i.e. MSC=Y) approvals: Please approv e at MSC=Y only. For preferred alternatives, use the non-preferred alternatives grid to id entify appropriate alternatives: https://uhgazure.sharepoint.com/sites/ CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID =0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B 6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&vie wid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2 Fsites%2FCST%2FCSDM%2FShared%20Documents%2FAZM%2FN F%20Alt%20Tables **Medications used solely for anti-obesity/weight l oss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfun ction, or sexual dysfunction purposes are NOT medically accepted ind ications and are NOT recognized as a covered benefit. Erectile dysfun ction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other t han ED.

2 . Revision History

Date	Notes
3/4/2022	Updated MSC criterion verbiage. Attached to Specialty formulary.