

## Clinical Policy: Request for Medically Necessary Drug on the PDL

Reference Number: OR.CP.PMN.1002

Effective Date: 10.01.21

Last Review Date: 08.25

Line of Business: Medicaid – Trillium Oregon Health Plan

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

The intent of the criteria is to ensure that members follow selection elements established by Trillium Oregon Health Plan for formulary drugs that are on the preferred drug list (PDL).

### FDA Approved Indication(s)

Varies by drug product.

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of Trillium Community Health Plan that formulary PDL drugs are **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Request for a PDL Drug (must meet all):

1. Prescribed indication is FDA-approved;\*  
*\*Requests for off-label use when there is no drug specific coverage criteria should also be reviewed against CP.PMN.53 – Off-Label Drug Use*
2. Request meets one of the following (a or b)
  - a. Request is for treatment of a condition funded by the Oregon Health Plan (OHP) (i, ii and iii):
    - i. Request falls on a funded line of the OHP Prioritized List;
    - ii. Members condition meets the definition of the funded line;
    - iii. Applicable OHP Prioritized List Guideline Note requirements are met;
  - b. OR.CP.PMN.234 criteria for Early and Periodic Screening, Diagnostic, and Treatment Benefit for Pediatric Members (EPSDT) is met;
3. Request meets one of the following (a or b):
  - a. Request meets drug specific coverage criteria adopted by the plan if applicable;
  - b. Request meets one of the following if no drug specific criteria has been adopted by the plan (ii or iii):
    - i. Dose does not exceed the FDA approved maximum recommended dose for the relevant indication and health plan approved daily quantity limit;
    - ii. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: up to 12 months**

## II. Continued Therapy

### A. Request for a PDL Drug (must meet all):

1. One of the following (a, b, or c):
  - a. Currently receiving medication via Centene benefit;
  - b. Member has previously met initial approval criteria;
  - c. State or health plan continuity of care programs apply to the requested drug and indication (e.g., seizures, heart failure, human immunodeficiency virus infection, and psychotic disorders [e.g., schizophrenia, bipolar disorder], depression, transplant, oncology) with documentation that supports that member has received this medication for at least 30 days (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one of the following (a or b):
  - a. New dose does not exceed the FDA-approved maximum recommended dose for the relevant indication and health plan approved daily quantity limit;
  - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: 12 months. Reference OR.PHAR.123 for approval requirements for members post hospital discharge and transition of care.**

**III. Diagnoses/Indications for which coverage is NOT authorized:** Not applicable

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

HIV: human immunodeficiency virus

PDL: preferred drug list

*Appendix B: Therapeutic Alternatives*

Varies by drug product

*Appendix C: Contraindications/Boxed Warnings*

Varies by drug product

## V. Dosage and Administration

Varies by drug product.

## VI. Product Availability

Varies by drug product

## VII. References

Not applicable

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from previously approved policy TCHP.PHAR.1906 Request for Medically Necessary Drug on the PDL	06.15.21	07.15.21
3Q 2022 annual review: added pathway for approval of EPSDT request that are non-funded and removed acne as condition is now funded; references reviewed and updated.	06.15.22	07.07.22
3Q 2023 annual review: no significant changes	07.03.23	09.19.23
3Q 2024 annual review: no significant changes	07.03.24	09.17.24
Edited I.A.2.b. to remove age from direction to EPSDT criteria as new 2025 YSHCN program expands EPSDT coverage to specific OHP members, added depression and transplant to list of continuity of care programs per current Centene standard approach.	10.16.24	11.19.24
3Q 2025 annual review; no significant changes	07.11.25	08.12.25

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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