

## Clinical Policy: No Coverage Criteria, Recent Label Changes Pending Clinical Policy Update

Reference Number: OR.CP.PMN.255

Effective Date: 05.01.26

Last Review Date: 04.26

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

This policy is to be used for PDL drugs that:\*†

- Require prior authorization where there are no specific guidelines or coverage criteria.
- Have drug specific clinical policies that are pending updates as a result of recent (within the last 6 months) label changes (e.g., newly approved indications, age expansions, new dosing regimens).

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***\*All requests for drugs prescribed as part, or in support of gender dysphoria treatment should be reviewed against OR.CP.PHAR.1002 Gender Dysphoria***

*†All requests for non-PDL drugs, under the pharmacy benefit, should be reviewed against OR.CP.PMN.1001 Request for Medically Necessary Drug Not on the PDL or medication specific prior authorization criteria when available*

### 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 all medical necessity determinations for PDL drug therapy without coverage criteria or pending clinical policy updates as a result of recent label changes be considered on a case-by-case basis by a physician, pharmacist, or ad hoc committee, using the guidance provided within this policy.

## I. Initial Approval Criteria

### A. Pharmacy Benefit: Labeled Use without Drug-specific Coverage Criteria or Pending Clinical Policy Updates as a Result of Recent Label Changes (must meet all):

1. Request is for a PDL drug;\*

*\*All requests for non-PDL drugs, under the pharmacy benefit, should be reviewed against OR.CP.PMN.1001 - Request for Medically Necessary Drug Not on the PDL.*

2. Request is not for a benefit excluded use (e.g., cosmetic);
3. One of the following (a or b):

- a. Requested drug does not have a drug-specific clinical policy or custom coverage criteria;

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- b. Requested drug has a drug-specific clinical policy that is pending clinical policy updates as a result of recent (within the last 6 months) label changes (e.g., newly approved indications, age expansions, new dosing regimens);
4. Diagnosis of one of the following (a or b):
  - a. A condition for which the product is FDA-indicated and -approved;
  - b. A condition supported by the National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1, 2A, or 2B;
5. If the requested drug is not first-line therapy, failure of an adequate trial of at least two preferred\* FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist, at maximum indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;  
*\*Generic is preferred, if available generically*
6. If request is for a **non-preferred PDL drug\***, failure of two preferred PDL drugs, when such agents exist, at maximum indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;  
*\*All requests for non-PDL drugs, under the pharmacy benefit, should be reviewed against OR.CP.PMN.1001 Request for Medically Necessary Drug Not on the PDL or medication specific prior authorization criteria when available*
7. For combination product or alternative dosage form or strength of existing drugs, medical justification\* supports inability to use the individual drug products concurrently or alternative dosage forms or strengths (e.g., contraindications to the excipients of all alternative products)  
*\*Use of a copay card or discount card does not constitute medical necessity*
8. Member has no contraindications to the prescribed agent per the prescribing information;
9. If applicable, prescriber has taken necessary measures to minimize any risk associated with a boxed warning in the product information label;
10. Request meets one of the following (a or b):
  - a. Dose does not exceed the FDA-approved maximum recommended dose for the relevant indication;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: Duration of request or 6 months (whichever is less)**

**B. Medical Benefit: Labeled Use without Drug-specific Coverage Criteria or Pending Clinical Policy Updates as a Result of Recent Label Changes (must meet all):**

1. Request is not for a benefit excluded use (e.g., cosmetic);
2. One of the following (a or b):
  - a. Requested drug does not have a drug-specific clinical policy or custom coverage criteria;
  - b. Requested drug has a drug-specific clinical policy that is pending clinical policy updates as a result of recent (within the last 6 months) label changes (e.g., newly approved indications, age expansions, new dosing regimens);
3. Diagnosis of one of the following (a or b):
  - a. A condition for which the product is FDA-indicated and -approved;
  - b. A condition supported by the National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1, 2A, or 2B;

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4. If the requested drug is not first-line therapy, failure of an adequate trial of at least two preferred\* FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist, at maximum indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;  
*\*Generic is preferred, if available generically*
5. If request is for a **non-preferred PDL drug\***, failure of two preferred PDL drugs, when such agents exist, at maximum indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;  
*\*All requests for non-PDL drugs, under the pharmacy benefit, should be reviewed against OR.CP.PMN.1001 Request for Medically Necessary Drug Not on the PDL or medication specific prior authorization criteria when available*
6. For combination product or alternative dosage form or strength of existing drugs, medical justification\* supports inability to use the individual drug products concurrently or alternative dosage forms or strengths (e.g., contraindications to the excipients of all alternative products)  
*\*Use of a copay card or discount card does not constitute medical necessity*
7. Member has no contraindications to the prescribed agent per the prescribing information;
8. If applicable, prescriber has taken necessary measures to minimize any risk associated with a boxed warning in the product information label;
9. Request meets one of the following (a or b):
  - a. Dose does not exceed the FDA-approved maximum recommended dose for the relevant indication;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: Duration of request or 6 months (whichever is less)**

## **II. Continued Therapy**

### **A. Pharmacy or Medical Benefit: Labeled Use without Drug-specific Coverage Criteria or Pending Clinical Policy Updates as a Result of Recent Label Changes (must meet all):**

1. Member meets 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, psychotic disorders [e.g., schizophrenia, bipolar disorder], oncology, depression, transplant) 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, request meets one of the following (a or b):
  - a. New dose does not exceed the FDA-approved maximum recommended dose for the relevant indication;
  - 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: Duration of request or 12 months (whichever is less)**

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

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – OR.CP.PMN.53 for Medicaid or evidence of coverage documents;
- B. Indications or diagnoses in which the drug has been shown to be unsafe or ineffective.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

PDL: preferred drug list

HIV: human immunodeficiency virus

*Appendix B: Therapeutic Alternatives*

Varies by drug product

*Appendix C: Contraindications/Boxed Warnings*

Varies by drug product

*Appendix D: General Information*

These criteria are to be used only when specific prior authorization criteria do not exist.

**V. Dosage and Administration**

Varies by drug product

**VI. Product Availability**

Varies by drug product

**VII. References**

1. Food and Drug Administration: Guidance for Industry Distributing Scientific and Medical Publications on Unapproved New Uses - Recommended Practices. October 2023. Available at: <https://www.fda.gov/media/173172/download>. Accessed July 10, 2025.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from previously approved policy CP.PMN.255 No Coverage Criteria, Recent Label Changes Pending Clinical Policy Update. Added redirection to the policy OR.CP.PHAR.1002 Gender Dysphoria at the top of policy for all agents requested as part of, or in support of gender dysphoria treatment.	03.31.26	04.21.26

**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

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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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note:**

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**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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