Regence Oregon and Utah | Regence Idaho and select counties of Washington

Independent licensees of the Blue Cross and Blue Shield Association

Medication Policy Manual

Policy No: dru513

Topic: Medical Exception Criteria for the Drug Exclusions with Alternatives List

Date of Origin: August 11, 2017

Committee Approval Date: September 19, 2024

Next Review Date: 2025

Effective Date: January 1, 2025

IMPORTANT REMINDER

This Medication Policy has been developed through consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and government approval status.

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

The purpose of Medication Policy is to provide a guide to coverage. Medication Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care.

Description

This policy functions as medical necessity criteria required for coverage exceptions to the "Drug Exclusions with Alternatives" benefit exclusion. This policy will allow coverage of medications with alternatives when the policy criteria are met.

PLEASE NOTE: This policy only applies to medications that are excluded from coverage and have covered drug alternatives. This policy does not apply to any other benefit exclusions.

Policy/Criteria

Most contracts require pre-authorization approval of a medication excluded from coverage under the "Drug Exclusions with Alternatives" contract provision prior to coverage.

I. Continuation of therapy (COT): A medication excluded from coverage under the "Drug Exclusions with Alternatives" contract provision may be considered medically necessary for COT when full policy criteria below are met, including quantity limit.

Please note: *Medications obtained as samples, coupons, or promotions, paying cash for a prescription ("out-of-pocket") as an eligible patient, or any other method of obtaining medications outside of an established health plan benefit (from your insurance) does NOT necessarily establish medical necessity. Medication policy criteria apply for coverage, per the terms of the member contract with the health plan.*

II. A medication excluded from coverage under the "Drug Exclusions with Alternatives" contract provision may be pre-authorized for coverage when medical necessity criteria are met. These medications may be considered medically necessary when **ALL** of the alternatives specified in the table located at the following links have been ineffective, not tolerated or all are medically contraindicated. These medications **MAY** also be subject to quantity limits. Please see the "Quantity Limits Medication List," also found under the links below.

Drug Exclusions with Alternatives:

Asuris Forms Page

Bridgespan Forms Page

Regence BlueShield of Idaho Forms Page

Regence BlueShield (Washington) Forms Page

Regence BlueCross BlueShield of Oregon Forms Page

Regence BlueCross BlueShield of Utah Forms Page

PLEASE NOTE: **After you click one of the above links, you will need to choose a formulary or "drug list" – if you are unsure of which drug list to choose for your plan, please call the Customer Service number on the back of your insurance card.**

III. Limitations and Authorization Period

A. Regence Pharmacy Services considers the medications in this policy to be coverable only under the pharmacy benefit (as self-administered medications).

B. Authorization **may** be reviewed at least annually. Clinical documentation (including, but not limited to chart notes) must be provided to confirm that current medical necessity criteria are met, and that the medication is providing clinical benefit, such as disease stability or improvement.

Position Statement

- Drug Exclusions with Alternatives are excluded from coverage under the pharmacy benefit contract unless deemed medically necessary.
- The medications in this policy have covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (OTC) alternatives.
- There is no evidence that these medications are safer or more effective than their therapeutically equivalent alternatives, but are more costly.

Revision History

Revision Date	Revision Summary
9/19/2024	Changed reauthorization from "shall" to "may" review annually. No other changes with this annual review.
9/14/2023	Clarified intent of policy (removed "drug exclusions" from Description and replaced with "excluded from coverage and have covered drug alternatives"). No criteria changes with this annual review.
4/25/2023	Added language to specify that medications pre-authorized may also be subject to quantity limits.
12/9/2022	No criteria changes with this annual update.
10/15/2021	Changed policy name from "Medical Exception Criteria for High-Cost Drug Exclusions" to "Drug Exclusions with Alternatives". Updated continuation of therapy (COT) language for clarification. No change to intent of coverage criteria.
10/28/2020	Added continuation of therapy (COT) criteria (no change to intent of coverage criteria).
4/22/2020	Updated links to appropriately route to new flyers.
11/12/2019	Updated links in policy for 2020 drug lists.
7/24/2019	No criteria changes with this annual update.
1/10/2019	Updated weblinks to correctly reflect 2019 high-cost drug exclusion lists.
11/29/2018	Removed table from policy and pointed to specific lists on web for alternatives.
10/5/2018	Removed Tekturna, Tekturna HCT, Nexium, esomeprazole magnesium, and Osmolex ER from policy.
8/17/2018	No changes to criteria with this annual update.
6/7/2018	Added Osmolex ER to policy.
4/30/2018	Updated drug list for new FDA approvals and policy additions. Updated document for rebranding.
12/13/2017	Updated drug list for new applicable new FDA approvals.
8/11/2017	New policy (effective 1/1/18).

Drug names identified in this policy are the trademarks of their respective owners.