UnitedHealthcare
Community Plan

Clinical Pharmacy Program Guidelines for Non-preferred Drugs- TEXAS

Program	Prior Authorization
Medication	Non-preferred Drugs
Markets in Scope	Texas

NOTE: If the member is CHIP, this criteria does not apply.

1. Coverage Criteria:

A. Authorization Criteria

1. A request for a non-preferred medication will be approved based on **all** of the following criteria

A. One of the following:

a. All of the following:

(a) One of the following:

i. Beneficiary must demonstrate failure to at least one (1) of the preferred formulary/PDL alternatives for the given diagnosis within the last 180 days**- Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.**

-OR-

ii. Beneficiary must demonstrate history of contraindication, intolerance or allergy to at least one (1) of the preferred formulary/PDL alternatives for the given diagnosis

-OR-

iii. The requested medication is being used for the treatment of stage-four advanced, metastatic cancer and associated conditions

-OR-

(b) There are no preferred formulary alternatives for the requested

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drug.

-OR-

b. The requested medication is a behavioral health medication and one of the following:

1. 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)

-OR-

2. The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge

-AND-

B. One of the following:

a. The requested drug is supported by FDA labeling for the patient's age

-OR-

b. The requested drug is supported by the appropriate compendia of literature† for the patient's age

-OR-

c. The prescriber attests they are aware of FDA labeled age limitations regarding the use of the drug and feels the treatment with the requested drug is medically necessary. (Document rationale for use).

†Compendia of current literature: • American Hospital Formulary Service Drug Information • National Comprehensive Cancer Network Drugs and Biologics Compendium • Thomson Micromedex DrugDex • Clinical Pharmacology• United States Pharmacopoeia-National Formulary (USP-NF)

Authorization will be issued for 365 days.

Program	Program type – Non-preferred Drugs
Change Control	
Date	Change

January 2018	Created Texas specific policy. State mandates a step through 1 preferred agent and a 180 day lookback
May 2018	Added note that this criteria does not apply to CHIP members.
September 2018	Added age check criteria
June 2019	Updated list of compendia of current literature.
February 2020	Updated criteria for patients with metastatic or stage four advanced or metastatic cancer