

New Hampshire Medicaid Fee-for-Service Program

Brand Name Multiple Source Prescription Drug Product Criteria

Approval Date: December 3, 2019

Criteria for Approval

1. Prescribers must obtain a prior authorization (PA) for any brand name, multiple source legend drug product that has an FDA “A”-rated generic equivalent (AA, AN, AO, AP, AT, or AB) listed in the *Approved Drug Products with Therapeutic Equivalence Evaluations* (Orange Book); **AND**
 - a. Patient must have experienced a therapeutic failure (inadequate response) to the “A”-rated generic or the patient must have experienced an adverse reaction to the “A”-rated generic; **OR**
 - b. In the prescriber’s opinion, transition to another generic in the same therapeutic category would represent an unacceptable risk to the patient; **OR**
 - c. Allergy to one of the components of the generic (e.g., dye). If multiple generics available, must try another generic; **AND**
 - d. In accordance with FDA regulations, the prescriber must submit a MedWatch form to the FDA to verify a documented failure and/or adverse reaction on an AB rated generic product. **DO NOT FAX FORM TO MAGELLAN RX MANAGEMENT.**
2. Non-preferred drugs on the Preferred Drug List (PDL) may require additional prior approval (PA).

Length of Approval: One year

Criteria for Denial

Prior approval will be denied if the approval criteria are not met.

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutic Committee	New	10/25/2007
Commissioner	Approval	11/20/2007
DUR Board	Revision	10/25/2010
Commissioner	Approval	02/10/2011
DUR Board	Review/Revision	03/20/2017
Commissioner	Approval	06/08/2017
DUR Board	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Revision	10/28/2019
Commissioner Designee	Approval	12/03/2019