New Hampshire Medicaid Fee-for-Service Program

New Drug Product Criteria

Approval Date: April 5, 2019

Background

After Food and Drug Administration (FDA) approval, new drugs are added to the First Data Bank (FDB) files. Currently, the New Hampshire Medicaid Fee for Service (FFS) program covers any new drug added to the FDB files unless its use is otherwise restricted by the Center for Medicare and Medicaid Services.

Proposal

As new drugs are added to the FDB files, Magellan RX Management will code the system so that pharmacies will receive a denial at POS of: **NCPDP code 70: drug not covered**.

The Medicaid medical director shall determine whether a newly approved drug will be covered unrestricted or shall require prior authorization criteria from Drug Utilization Review (DUR) Board.

Restricted coverage will continue for a period of six months until the DUR Board has been given an opportunity to recommend coverage criteria or the Medicaid medical director determines that there will be unrestricted coverage of the new drug.

New Hampshire Medicaid FFS program will cover no new drug until it has either been reviewed by the DUR or has received an exemption from any authorization from the state's Medicaid medical director.
Medications

All FDA-approved medications shall be added to the NH Medicaid FFS program system as restricted coverage for their first six months on the market (as determined by the date of their addition to FDB file).

For drugs belonging to therapeutic drug classes that are subject to the Preferred Drug List (PDL), all drugs will be considered non-preferred until the class is again up for review.

For drugs that fall into categories that are subject to restrictions imposed by clinical prior authorizations (PA), a six-month PA will be imposed until clinical review has been undertaken by DUR. If review has not occurred by six months, the drug will be added to existing PA initiatives using the existing criteria for override.

For drugs that do not fall into any existing management tools, a six-month PA will be imposed until clinical review has been undertaken by DUR or the Medicaid medical director has determined that no restrictions shall be placed on the newly approved drug. However, if the review or an exemption has not occurred by six months, the drug will remain restricted until said review or exemption occurs.

Exemptions

If the Medicaid medical director determines that a new drug should be exempted from the six-month exclusion period, then the Medicaid medical director may make an exemption and allow for immediate coverage of the drug. Categorical exemption will be applied to antiretrovirals and chemotherapeutic drugs used to treat cancer.

Criteria for Approval

1. Allergy to all medications not requiring prior approval.
2. Contraindication to or drug-to-drug interaction with all medications not requiring prior approval.
3. History of unacceptable/toxic side effects to all medications not requiring prior approval.
4. Therapeutic failure of all medications within the same class not requiring prior approval.
5. An indication that is unique to a non-preferred agent and is strongly supported by peer-reviewed literature or an FDA-approved indication.

Length of Authorization: One year
References

- The Omnibus Reconciliation Act of 1993 (OBRA '93) (P.L. 103-66) section 1927

Revision History

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