Policy Title:	Medicaid Oncology/Hematology Preferred Drug Policy		
		Department:	PHA
Effective Date:	12/01/2020		
Review Date:	11/2020, 11/2021		
Revision Date:	11/2020, 11/2021		

Purpose: To support the use of preferred products that are safe and effective.

Scope: Medicaid

Policy Statement:

The Medicaid Oncology/Hematology Preferred Drug Policy will provide coverage of preferred medications when it is determined to be medically necessary and is covered under the Pharmacy Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

Procedure:

Coverage of Medicaid drugs will be reviewed prospectively via the prior authorization process based on criteria below. Patients who have previously received the requested medication within the past 365 days are not subject to the preferred drug requirements.

Target Drug	**Medications needed to be used prior to receiving the Target Drug**
Procrit, Epogen	All indications: Trial of Retacrit
Aranesp	All indications: Trial of Retacrit
Mircera	All indications: Trial of Retacrit
Short Acting Colony Stimulating Factors: Nivestym, Neupogen, Granix	All indications: Trial of Zarxio
Long Acting Colony Stimulating Factors^{++}: Fulphila, Nyvepria, Udenyca	All indications: Trial of Zarxio AND Ziextenzo, Neulasta/Neulasta Onpro
Somatostatin Analogs: Sandostatin^{+} & Somatuline^{+}	All indications: Trial of Octreotide
LHRH Agonists and Antagonist: Lupron, Lupron Depot, Trelstar^{+}, Zoladex^{+}, Vantas^{+}, Firmagon^{+}, Eligard	Prostate Cancer: Trial of Eligard Breast Cancer: Trial of Lupron/Eligard
Prolia	Trial of Zometa/Reclast or Aredia

Xgeva	Trial of Zometa/Reclast or Aredia

[+]Non-formulary products will require a failure of the preferred products listed above.
[++]Non-formulary Long acting Colony Stimulating Factors will require a failure of both Zarxio AND Ziextenzo.
*** Requests will also be reviewed to National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) if applicable.***

Investigational use: All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

For additional information on the Medicaid Preferred Drugs, please reach out to member services at Neighborhood Health Plan of RI at 800-459-6019.