Clinical Guideline

Guideline Number: PG076, Ver. 1

Medical Necessity Prior Authorization Criteria

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Oscar may delegate utilization management decisions of certain services to third-party delegates who may develop and adopt their own clinical criteria.

The clinical guidelines are applicable to all commercial plans. Services are subject to the terms, conditions, limitations of a member's plan contracts, state laws, and federal laws. Please reference the member's plan contracts (e.g., Certificate/Evidence of Coverage, Summary/Schedule of Benefits) or contact Oscar at 855-672-2755 to confirm coverage and benefit conditions.

Summary

Oscar Health has developed pharmacy policies to promote clinically appropriate and cost-effective use of prescription medications. Oscar pharmacy formularies cover drugs that are approved by the U.S. Food and Drug Administration (FDA) and are broadly used and accepted by healthcare professionals to treat different conditions. This policy should be used to review authorization requests for non-preferred drugs that have one or more preferred drugs in a same or similar class on formulary, specified as MNPA on the formulary.

Definitions

"Compendia" are summaries of drug information and medical evidence to support decision-making about the appropriate use of drugs and medical procedures.

"Formulary" refers to a health plan's covered drug list. Drugs on the list may have requirements that need to be met first before they can be used.

"Non-formulary products" are not covered because there are safe and comparably effective products available.

"Therapeutic class" refers to a group of drugs that can be used to effectively treat a particular health condition.

Medical Necessity Criteria for Initial Authorization

1. Oscar covers a non-formulary drug with preferred drugs on formulary (as indicated by MNPA on formulary) when **ALL** of the following criteria are met:
    a. The requested product is being used for an FDA-approved indication **OR** an indication supported by medical evidence from compendia or current literature (e.g. Clinical Pharmacology, Micromedex, current accepted clinical guidelines); *AND*
    b. **ONE** of the following is true:
        i. The patient has demonstrated trial and inadequate treatment to **ALL** preferred formulary alternatives in the same therapeutic class for the given diagnosis, as evidenced by medical records; *OR*
        ii. The patient has demonstrated intolerance to or is expected to have an adverse reaction or contraindication to the preferred formulary alternatives.

Experimental or Investigational / Not Medically Necessary

The use of non-formulary products for any other indication that is not supported by the FDA or compendia is *not covered* by Oscar as it is considered experimental, investigational, or unproven.

Clinical Guideline Revision / History Information

Original Date: 11/05/2020 Reviewed/Revised: