

Clinical Policy: No Coverage Criteria/Off-Label Use Policy

Reference Number: CP.PMN.53

Effective Date: 09.12.17

Last Review Date: 11.19

Line of Business: Medicaid, HIM-Medical Benefit

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy is to be used to determine medical necessity of formulary, existing or newly approved drug therapy where there are no coverage criteria and for off-label requests for an indication, treatment regimen, or patient population not approved by the U.S. Food and Drug Administration (FDA).

FDA Approved Indication(s)

Varies by drug product.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that all medical necessity determinations for drug therapy without Centene[®] coverage criteria or for off-label uses be considered on a case-by-case basis by a physician, pharmacist or ad hoc committee, using the guidance provided within this policy.

I. Initial Approval Criteria

A. Labeled Use without Coverage Criteria (must meet all):

1. Request is for a drug without custom coverage criteria;
**All requests for non-formulary drugs, under the pharmacy benefit, should be reviewed against CP.PMN.16 - Request for Medically Necessary Drug Not on the PDL.*
2. Member meets one of the following (a or b):
 - a. For Medicaid pharmacy requests: Failure of an adequate trial of at least two preferred FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist, at maximum indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
 - b. For HIM-Medical Benefit requests: Failure of an adequate trial of at least two FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist, at maximum indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
3. If request is for combination product or alternative dosage form or strength of existing drugs, medical justification* supports inability to use the individual drug products concurrently or alternative dosage forms or strengths (e.g., contraindications to the excipients of all alternative products);

**Use of a copay card or discount card does not constitute medical necessity*

4. Member has no contraindications to the prescribed agent per the prescribing information;
5. If applicable, prescriber has taken necessary measures to minimize any risk associated with a boxed warning in the product information label;
6. Dose does not exceed the FDA-approved maximum recommended dose for the relevant indication.

Approval duration: Duration of request or 6 months (whichever is less)

B. Off-Label Use (must meet all):

1. There are no pharmacy and therapeutic committee approved off-label use criteria for the diagnosis;
2. Use is supported by one of the following (a, b, or c):
 - a. The National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1 or 2A (*see Appendix D*);
 - b. Evidence from at least two high-quality, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i – iv):
 - i. Adequate representation of the member’s clinical characteristics, age, and diagnosis;
 - ii. Adequate representation of the prescribed drug regimen;
 - iii. Clinically meaningful outcomes as a result of the drug therapy in question;
 - iv. Appropriate experimental design and method to address research questions (*see Appendix E for additional information*);
 - c. Micromedex DrugDex[®] with strength of recommendation Class I or IIa (*see Appendix D*);
3. Treatment is not for a benefit-excluded use (e.g., cosmetic);
4. Prescribed by or in consultation with an appropriate specialist for the diagnosis;
5. Failure of an adequate trial of at least two FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist, at maximum indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
6. Member has no contraindications to the prescribed agent per the product information label;
7. If applicable, prescriber has taken necessary measures to minimize any risk associated with a boxed warning in the product information label;
8. Dosing regimen and duration are within dosing guidelines recommended by clinical practice guidelines and/or medical literature.

Approval duration: Duration of request or 6 months (whichever is less)

II. Continued Therapy

A. All Requests from Section I (must meet all):

1. Member meets one of the following (a, b, or c):
 - a. Currently receiving medication via Centene benefit;
 - b. Member has previously met initial approval criteria;
 - c. State or health plan continuity of care programs apply to the requested drug and indication (e.g., seizures, heart failure, human immunodeficiency virus infection,

and psychotic disorders [e.g., schizophrenia, bipolar disorder], oncology) with documentation that supports that member has received this medication for at least 30 days AND, if off-label, use is supported by one of the following (i, ii, or iii):

- i. The NCCN Drug Information and Biologics Compendium level of evidence 1 or 2A (*see Appendix D*);
 - ii. Evidence from at least two, high-quality, published studies in peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (1 – 4):
 - 1) Adequate representation of the member’s clinical characteristics, age, and diagnosis;
 - 2) Adequate representation of the prescribed drug regimen;
 - 3) Clinically meaningful outcomes as a result of the drug therapy in question;
 - 4) Appropriate experimental design and method to address research questions (*see Appendix E for additional information*);
 - iii. Micromedex DrugDex with strength of recommendation Class I or IIa (*see Appendix D*);
2. Member is responding positively to therapy;
 3. If request is for a dose increase (quantity or frequency), member has been titrated up from the lower dose with documentation of partial improvement, and the new dose does not exceed dosing guidelines recommended by the product information label or clinical practice guidelines and/or medical literature.

Approval duration: Duration of request or 12 months (whichever is less)

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Indications or diagnoses in which the drug has been shown to be unsafe or ineffective.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

HIV: human immunodeficiency virus

NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

Varies by drug product

Appendix C: Contraindications/Boxed Warnings

Varies by drug product

Appendix D: General Information

- These criteria are to be used only when specific prior authorization criteria do not exist.
- The U.S. FDA approves drugs for specific indications included in the drug’s product information label. The approval by the FDA means that the company can include the information in their package insert. Omission of uses for a specific age group or a specific disorder from the approved label means that the evidence required by law to allow their inclusion in the label has not been submitted to the FDA. Off-label, or “unlabeled,” drug use is the utilization of an FDA-approved drug for indications,

treatment regimens, or populations other than those listed in the FDA-approved labeling. Many off-label uses are effective and well-documented in the peer-reviewed literature, and they are widely used even though the manufacturer has not pursued the additional indications. Refer to the drug’s FDA-approved indication(s) and labeling (varies among drug products).

- NCCN Categories of Evidence and Consensus:
 - Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
 - Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
 - Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
 - Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.
- Micromedex DrugDex Strength of Evidence, Strength of Recommendation, and Efficacy Definitions (Tables 1, 2, and 3):

Table 1. Strength of Recommendation		
Class I	Recommended	The given test or treatment has been proven to be useful, and should be performed or administered.
Class IIa	Recommended, In Most Cases	The given test, or treatment is generally considered to be useful, and is indicated in most cases
Class IIb	Recommended, In Some Cases	The given test, or treatment may be useful, and is indicated in some, but not most, cases.
Class III	Not Recommended	The given test, or treatment is not useful, and should be avoided.
Class Indeterminate	Evidence Inconclusive	Not applicable

Table 2. Strength of Evidence	
Category A	Category A evidence is based on data derived from: Meta-analyses of randomized controlled trials with homogeneity with regard to the directions and degrees of results between individual studies. Multiple, well-done randomized clinical trials involving large numbers of patients
Category B	Category B evidence is based on data derived from: Meta-analyses of randomized controlled trials with conflicting conclusions with regard to the directions and degrees of results between individual studies. Randomized controlled trials that involved small numbers of patients or had significant methodological flaws (e.g., bias, drop-out rate, flawed analysis, etc.). Nonrandomized studies (e.g., cohort studies, case-control studies, observational studies)
Category C	Category C evidence is based on data derived from: Expert opinion or consensus, case reports or case series
No Evidence	Not applicable

Table 3. Efficacy		
Class I	Effective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective
Class IIa	Evidence Favors Efficacy	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy.
Class IIb	Evidence is Inconclusive	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion argues against efficacy.
Class III	Ineffective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is ineffective.

Appendix E: Appropriate Experimental Design Methods

- Randomized, controlled trials are generally considered the gold standard; however:
 - In some clinical studies, it may be unnecessary or not feasible to use randomization, double-blind trials, placebos, or crossover.
 - Non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
- Case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

V. Dosage and Administration

Varies by drug product

VI. Product Availability

Varies by drug product

VII. References

1. Food and Drug Administration. Good Reprint Practices for the Distribution of Medical Journal Articles and Medical or Scientific Reference Publications on Unapproved New Uses of Approved Drugs and Approved or Cleared Medical Devices. January 2009. Available at: <http://www.fda.gov/RegulatoryInformation/Guidances/ucm125126.htm>. Accessed August 16, 2019.
2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 16, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Reviewed.	12.14	12.14
Updated criteria E with (i.e. improved health outcomes, reduced adverse health event or reduced adverse drug event)”	05.15	05.15
Converted to new guideline template	11.15	11.15

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Guideline reviewed Modified initial approval duration to 3 months or the requested length of therapy, whichever is less		
Converted to new template. Added criteria for labeled use without custom criteria. Added initial approval criteria for off-label use to align with off-label use policy & procedures. Allowed COC for listed disease states in continued approval.	09.12.17	11.17
2Q 2018 annual review: no significant changes; Section IA2a/b: added “approved within the last 12 months”; Section IB: Added the requirement that a P & T off-label use criteria must not be available as several criteria address off-label uses.	02.02.18	05.18
4Q 2018 annual review: HIM Medical Benefit added; added criteria for combinations products and alternative dosage forms or strengths of existing drugs; added redirection to CP.PMN.16 for non-PDL agent under the pharmacy benefit; for drugs without custom coverage criteria added requirement for trial and failure of at least two FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist; references reviewed and updated.	08.14.18	11.18
Removed DrugDex IIb support for off-label use.	02.19.19	05.19
4Q 2019 annual review: added requirement that member does not have any contraindications for labeled use without coverage criteria; references reviewed and updated.	08.27.19	11.19
Clarified for Labeled Use without Coverage Criteria: failure of two FDA-approved agents must be PDL agents for Medicaid pharmacy requests.	03.09.20	
Replaced the terms “PDL” to “formulary” agents for clarity per PA Ops request.	04.22.20	
Revised “formulary agents” to “preferred agents” for clarity per PA Ops request.	05.18.20	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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