Clinical Policy: Duplicate Therapy

Reference Number: IL.PMN.351
Effective Date: 6.13.24
Last Review Date: 6.13.24
Line of Business: IL YouthCare

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

IL YouthCare Duplicate Therapy Edits: Restrictions on claims implemented to prevent members from receiving excessive medication regimens within the same (or similar) drug classes.

Overrides will not be possible at point-of-sale. Prior authorization will be required for review if the provider deems the duplicate therapy is medically necessary outside of the listed restrictions. Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that the request is medically necessary and considered standard of care.

IL YouthCare Appropriate Use and Safety Edits
https://www.ilyouthcare.com/providers/provider-resources.html

Policy/Criteria

- Pharmacist shall review prior authorization requests that exceed the restrictions identified by drug class in the table below
    - Pharmacist may approve the request if medically necessary and within standard of care
        - Examples where approval is appropriate:
            - Provider is changing therapy (discontinuing duplicate agent)
            - Provider is requesting multiple strengths of the same drug for dose titration
            - Requested therapy is supported by medical literature as standard of care
            - Concurrent antipsychotic use for patient stable on current regimen
            - Concurrent opioid use for cancer patients
            - Antidepressant use for patients on multiple antidepressants for multiple indications such as migraine and depression, etc.
            - Benzodiazepines exceeding polytherapy limits for patients with seizure disorders filling benzodiazepines for maintenance use (e.g., oral clobazam, oral diazepam, etc.) and for rescue use (e.g., rectal diazepam, intranasal midazolam)

**The examples above are just some of the instances when approval may be required for medical necessity and do not*

cover all potential scenarios when medically necessary approvals may be appropriate. Please use your clinical discretion when reviewing all cases for medical necessity

- Approval duration: 12 months

- If medical necessity is not established, the case should be denied based on the restrictions identified by drug class

Drug Class(es)	Limit	Note
ACEI and ARB	**Restricted to one drug per month	-
ADHD- immediate release	Restricted to two drugs per month	-
ADHD- long acting	Restricted to one drug per month	-
Alpha Agonists (for ADHD)	Restricted to one drug per month; applies only to age <18 YO	
Antidepressants	Restricted to two drugs per month	-
Atypical Antipsychotics	Restricted to one drug per month	-
Benzodiazepines	Restricted to two drugs per month	-
Diabetes Medications (sulfonylureas/ meglitinides)	Restricted to one drug per month	
Sedative Hypnotics	Restricted to one drug per month	-
Opioid Max Fill	**Restricted to two fills (claims) per month	**Refer to IL.PMN.97 Opioid Analgesic Criteria
SSRI and SNRI	**Restricted to one drug per month	-
Tricyclic Antidepressants	Restricted to one drug per month	-

I. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ACEI- Angiotensin Converting Enzyme Inhibitor
ADHD- Attention Deficit Hyperactive Disorder
ARB- Angiotensin Receptor Blocker
SNRI- Selective norepinephrine reuptake inhibitor
SSRI- Selective serotonin reuptake inhibitor

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
Refer to each product's prescribing information.

II. References

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2023. Available at: https://www.clinicalkey.com/pharmacology/. Updated periodically. Accessed January 26. 2024.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Criteria created for alignment with Meridian IL Appropriate Use and Safety Edits	06.13.2024	

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.