Clinical Policy: Early and Periodic Screening, Diagnostic, and Treatment Benefit for Pediatric Members

Reference Number: CP.PMN.234
Effective Date: 06.01.20
Last Review Date: 05.26
Line of Business: Medicaid

Revision Log

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

Description

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the Medicaid program's benefit for low-income infants, children, and adolescents, which provides a comprehensive array of prevention, diagnostic, and treatment services as specified in Section 1905(r) of the Social Security Act. The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

This prior authorization policy provides coverage guidelines for medication requests through the EPSDT benefit and should be used in conjunction with the drug-specific or general medical necessity policy.*^

**When available, drug-specific policies supersede general medical necessity policies. If no drug-specific policies exist for the requested agent, refer to CP.PMN.255 (for FDA-labeled uses)/CP.PMN.53 (for off-label uses) for formulary agents and CP.PMN.16 for non-formulary agents.*

^If request is for a glucagon-like peptide-1 (GLP-1) receptor agonist for weight management for pediatric members (e.g., liraglutide [Saxenda®], semaglutide [Wegovy®], tirzepatide [Zepbound®]), refer to CP.PMN.305.

FDA Approved Indication(s)

Refer to the prescribing information for the requested agent.

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 the requested agent is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Medication Request Through EPSDT Benefit* (must meet all)**:**

**Refer to the corporate policy CP.PMN.305 for requests for GLP-1 receptor agonists for weight management for pediatric members. This policy may not apply to all states and plans; see Appendix D in CP.PMN.305 for details*

1. Age < 21 years or the state-specific maximum age for coverage under the EPSDT benefit, whichever is lower;

2. Member meets one of the following (a or b):
   a. The initial approval criteria in the drug-specific or general medical necessity policy are met;
      When available, drug-specific policies supersede general medical necessity policies. If no drug-specific policies exist for the requested agent, refer to CP.PMN.255 (for FDA-labeled uses)/CP.PMN.53 (for off-label uses) for formulary agents and CP.PMN.16 for non-formulary agents
   b. All of the following (i, ii, and iii):
      i. The requested agent is medically necessary* to correct or ameliorate the member's physical or mental condition as evidenced by one of the following (1, 2, or 3; *provider must submit supporting documentation*):
         **Benefit exclusions may not apply; evaluation for EPSDT should be based solely on medical necessity, unless the requested drug is not part of the Medicaid Drug Rebate Program (MDRP) or the state Medicaid agency allows coverage of non-MDRP drugs (see Appendix D)*
         1) The National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1, 2A, or 2B (*see Appendix F*);
         2) 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 (a – d):
            a) Adequate representation of the member's clinical characteristics, age, and diagnosis;
            b) Adequate representation of the prescribed drug regimen;
            c) Clinically meaningful outcomes as a result of the drug therapy in question;
            d) Appropriate experimental design and method to address research questions (*see Appendix E for additional information*);
         3) Micromedex DrugDex® with strength of recommendation Class I or IIa (*see Appendix F*);
      ii. Failure of formulary alternatives if required in the drug-specific or general medical necessity policy, unless clinically significant adverse effects are experienced, all are contraindicated, none are available, or all are inappropriate for the member (e.g., due to the member's age or functional capacity);
         When available, drug-specific policies supersede general medical necessity policies. If no drug-specific policies exist for the requested agent, refer to CP.PMN.255 (for FDA-labeled uses)/CP.PMN.53 (for off-label uses) for formulary agents and CP.PMN.16 for non-formulary agents
      iii. The requested agent and prescribed dose are not considered experimental or investigational for the member's diagnosis and age.

Approval duration: Duration allowed in the drug-specific or general medical necessity policy or 6 months

II. Continued Therapy

A. Medication Request Through EPSDT Benefit* (must meet all)**:**

Refer to the corporate policy CP.PMN.305 for requests for GLP-1 receptor agonists for weight management for pediatric members. This policy may not apply to all states and plans; see Appendix D in CP.PMN.305 for details

1. Member meets one of the following (a, b, or c):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
   c. The continued therapy criteria in the drug-specific or general medical necessity policy are met;
      When available, drug-specific policies supersede general medical necessity policies. If no drug-specific policies exist for the requested agent, refer to CP.PMN.255 (for FDA-labeled uses)/CP.PMN.53 (for off-label uses) for formulary agents and CP.PMN.16 for non-formulary agents
2. Member is responding positively to therapy;
3. If request is for a dose increase, the prescribed dose is not considered experimental or investigational for the member's diagnosis and age.

Approval duration: Duration allowed in the drug-specific or general medical necessity policy or 12 months

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

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

EPSDT: early and periodic screening, diagnostic and treatment
FDA: Food and Drug Administration
GLP-1: glucagon-like peptide-1
MDRP: Medicaid Drug Rebate Program

Appendix B: Therapeutic Alternatives

Refer to the drug-specific or general medical necessity policy.*

**When available, drug-specific policies supersede general medical necessity policies. If no drug-specific policies exist for the requested agent, refer to CP.PMN.255 (for FDA-labeled uses)/CP.PMN.53 (for off-label uses) for formulary agents and CP.PMN.16 for non-formulary agents.*

Appendix C: Contraindications/Boxed Warnings

Refer to the prescribing information for the requested agent.

Appendix D: General Information

- Medicaid EPSDT website: https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html
- Age for EPSDT benefit eligibility: under the age of 21, or, at the option of the state, under the age of 20, 19, or 18 as the state may choose.[1]
- EPSDT benefit coverage under Section 1905(r)(5) of the Social Security Act includes "Such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."[1]
  - A service need not cure a condition in order to be covered under EPSDT.[2]

- Services that maintain or improve the child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.[2]
- Categories of Medicaid-covered services listed in Section 1905(a) and/or 1905(r) of the Social Security Act include:
  - Immunization in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
  - Dental care needed for relief of pain, infection, restoration of teeth, or maintenance of dental health
  - Emergency, preventive, or therapeutic treatment for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures
  - Treatment for defects in vision
  - Treatment for defects in hearing
  - Treatment for tobacco cessation for a pregnant woman*
    **Requested agent must be recommended for pregnant women by the Public Health Service guidelines on treating tobacco use or recognized as effective by the Secretary of Health and Human Services*
  - Preventive treatment assigned a grade of A or B by the United States Preventive Services Task Force: https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P&grades%5B%5D=A&grades%5B%5D=B
  - Treatment of a mental health or substance use condition, including medication-assisted treatment for opioid-use disorders
  - Primary or secondary treatment for sickle cell disease in members who have had a stroke or are at high risk of stroke, including deferoxamine chelation in members receiving chronic blood transfusions

- A state may consider the relative cost effectiveness of alternatives as part of the prior authorization process. States may cover services in the most cost effective mode as long as the less expensive service is equally effective and actually available.[2]
- EPSDT does not require coverage of treatments that are experimental or investigational. Neither the Federal Medicaid statute nor the regulations define what constitutes an experimental treatment. The state's determination of whether a service is experimental must be reasonable and should be based on the latest scientific information available. Medicare guidance on whether a service is experimental or investigational is not determinative of the issue and may not be relevant to the pediatric population.[2]
- The MDRP is a program authorized by Section 1927 of the Social Security Act that helps offset the Federal and state costs of outpatient prescription drugs dispensed to Medicaid patients. To have their drugs covered under Medicaid, drug manufacturers are required to enter into 3 agreements: 1) a National Drug Rebate Agreement with the Secretary of the Department of Health and Human Services, 2) a pricing agreement for the Section 340B Drug Pricing Program administered by the Health Resources and Services Administration, and 3) a master agreement with the Secretary of Veterans Affairs for the Federal Supply Schedule. A drug and its intended use may be considered medically necessary and approvable under EPSDT while being an excluded use under the member's

plan as long as it is part of the MDRP, unless the state Medicaid agency directs otherwise:

State: Plan* *Note: Not all plans below may be utilizing this policy	Does the state Medicaid agency allow coverage of drugs under EPSDT for drugs not on the MDRP?	Policy applicability as of June 2026, regardless of MDRP status
AZ: AZCH	No, unless the diagnosis is a covered benefit (not an exclusion) AND no other treatment options apply	No, use AZ.CP.PMN.234
AR: Arkansas	No	Yes
CA: CAHW/ HNCA	Carve out for Pharmacy Benefit; Yes for Medical Pharmacy	Not applicable
DE: DE 1st	Yes	Yes
FL: SSHP	No	Yes
GA: PSHP	Yes	Yes
HI: Ohana	Yes	Yes
IA: ITC	No	Not applicable
IL: Meridian IL	Yes	Yes
IL: Youthcare	Yes	Yes
IN: MHS IN	Yes	No (send to plan)
KS: Sunflower	No	Not applicable
KY: Wellcare of KY	Carve out for Pharmacy Benefit; For Medical Benefit: No	Not applicable
LA: LHCC	No	No, use State PDL criteria
MI: Meridian MI	Yes	Yes
MO: Home State	Not applicable (i.e., Full Medicaid pharmacy benefit carve-out)	Not applicable
MS: Magnolia	Carve out for Pharmacy Benefit; Yes for Medical Pharmacy	Not applicable
NC: CCH	Yes	No, use State PDL criteria
NE: NTC	No	No, use State PDL criteria
NH: NHHF	Yes	Yes
NJ: Fidelis	Yes	Yes
NV: NVSS	Yes	Yes
NY: Fidelis (Medicaid)	Carve out for Pharmacy Benefit; For Medical Benefit: No, unless the diagnosis is a covered benefit (not an exclusion) AND no other treatment options apply	Not applicable
NY: Fidelis (CHIP, Essential)	Not applicable	Not applicable
OH: Buckeye	Carve out for Pharmacy Benefit; Yes for Medical Pharmacy	Not applicable
OK: Oklahoma Complete Health	Yes	Yes

State: Plan* *Note: Not all plans below may be utilizing this policy	Does the state Medicaid agency allow coverage of drugs under EPSDT for drugs not on the MDRP?	Policy applicability as of June 2026, regardless of MDRP status
OR: Trillium	Yes	No, use OR.CP.PMN.234
PA: PAHW (Medicaid, CHIP)	Not applicable	Not applicable
SC: ATC	Yes, and no redirection to PDL agents allowed	Yes
TX: Superior	No	Not applicable
WA: CCWA	Yes, but must document medical justification	No, use WA.CP.PMN.234
WI: MHS	Not applicable (i.e., Full Medicaid pharmacy benefit carve-out)	Not applicable

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.

Appendix F: Evidence Categories

- 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.

Table 1. Strength of Recommendation		
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.

V. Dosage and Administration

Refer to the prescribing information for the requested agent.

VI. Product Availability

Refer to the prescribing information for the requested agent.

VII. References

1. Social Security Act, Section 1905. Available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm. Accessed January 26, 2026.
2. EPSDT Coverage Guide. Published June 2014. Available at: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf. Accessed January 26, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: no significant changes; added legacy WellCare line of business (WCG.CP.PMN.234 to be retired) with initial approval duration consolidated to 6 months; references reviewed and updated.	01.24.22	05.22
Updated link to United States Preventive Services Task Force preventive treatment recommendations. Template changes applied to continued therapy section.	08.22.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	01.23.23	05.23
For determination of medical necessity, added Appendix E to describe supporting documentation required to support medical necessity (adapted from CP.PMN.53 Off-Label Use criteria), added to Appendix D clarification that plan specific benefit excluded uses do not apply.	09.19.23	11.23
2Q 2024 annual review: no significant changes; references reviewed and updated.	02.06.24	05.24
2Q 2025 annual review: no significant changes; references reviewed and updated. Per Compliance, revised footnote for medically necessary treatment that "Benefit exclusions do not apply; evaluation for EPSDT should be based solely on medical necessity" to include "unless the requested drug is not part of the MDRP", with additional information included in Appendix D.	04.10.25	05.25
Moved definition of medical necessity from Appendix E into approval criteria; moved example categories covered by Section 1905(a) and/or 1905(r) of the Social Security Act from approval criteria into Appendix D. Added note to refer to CP.PMN.305 for requests for GLP-1 receptor agonists for weight management for pediatric members; added state Medicaid agency directions regarding MDRP to Appendix D based on confirmed responses from each health plan; clarified reference to CP.PMN.53 (off-label uses) for formulary agents to also include CP.PMN.255 (FDA-labeled uses).	02.16.26	02.26
2Q 2026 annual review: no significant changes; references reviewed and updated. Clarified that CP.PMN.305 may not apply to all states and plans.	05.05.26	05.26

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Updated Appendix D.		

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.

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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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