PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **November 20, 2020**

Subject: **Specialty Drugs Prior Authorization (PA) Criteria**

Summary: Specialty Drugs PA Criteria policy approved by Louisiana Department of Health

AmeriHealth Caritas Louisiana would like to make you aware of the attached policies that have been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54 and **will become effective December 20, 2020**.

Questions:
Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert?
You can always find a complete listing of provider alerts on the Newsletters and Updates page of our website.

Where can I find more information on COVID-19?
AmeriHealth Caritas Louisiana has updated its website to streamline communications and important notifications about COVID-19. Please visit http://amerihealthcaritasla.com/covid-19 for update-to-date information for both providers and members, including frequently asked questions, cancellations and postponements, and important provider alerts from AmeriHealth Caritas Louisiana and the Louisiana Department of Health.

Pharmacy Policy Title: Specialty Drugs
Recent review date: 7/2020
New review date: 7/2021

Field Name	Field Description
Prior Authorization Group Description	**Specialty Drugs**
Drugs	Oral and injectable specialty drugs without drug or class specific prior authorization criteria *** The Oncology Drugs prior authorization criteria will be applied to oncology drugs without drug or class specific criteria***
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	N/A
Coverage Duration	If all of the conditions are met, requests will be approved for up to 6 months. If the conditions are not met, the request will be sent to a Medical Director/clinical reviewer for medical necessity review.
Other Criteria	**All of the following criteria must be met:** • **The drug is requested through the medical benefit** • The drug is requested for an appropriate use (per the references outlined in "Covered Uses" • The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses") • ~~If the request is for a non-formulary/non-preferred drug documentation has been provided that the member has tried and failed two formulary/preferred drugs appropriate for the~~ **Documentation has been provided of a trial and failure of an appropriate alternative first line therapy, if one exists, for the** requested use (per the references outlined in "Covered Uses" or has a medical reason why these drug(s) cannot be used (e.g. intolerance, contraindication) • **If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available**

Revision/Review Date ~~5/2020~~ **7/2020**	o **The provider has either verbally or in writing submitted a member specific reason why the reference biologic is required based on the member's condition or treatment history** **Physician/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**