Medical Necessity

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To see the list of the current publication of the Coordinated Care of Washington, Inc. Preferred Drug List (PDL), please visit:
https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf

Medical necessity

Medical Necessity
This is a general pharmacy program policy used to determine medical necessity for drugs without a drug specific policy. For covered drugs and conditions, in cases where the criteria are not met, the clinical reviewer may use their professional judgement to determine there is a medically necessary need and approve on a case-by-case basis. The clinical reviewer may choose to use the reauthorization criteria when a patient has been previously established on therapy and is new to Apple Health.

Clinical policy:

Clinical Criteria	
Medical Necessity	Drugs may be considered medically necessary when all the following documented criteria is met: 1. For patients 21 years of age or older, the requested agent is not: a. Excluded from coverage; **OR** b. Being used to treat a medical condition/disease state that is excluded from coverage; **AND** 2. The following are met: a. Prescribed in accordance with FDA labeling; **OR** b. Prescribed for a condition supported in compendia, classified as follows: i. Strength of evidence*: Category A or B; **AND** ii. Strength of recommendation*: Class 1 or 2a; **AND** c. Is prescribed within the FDA labeling or is compendia supported for age, dose and dosing frequency; **AND** 3. Patient meets one of the following: a. Documentation of a history of failure, contraindication, or intolerance to all preferred first-line therapies as recommended in North American or World Health Organization (WHO) evidence based practice guidelines (other guidelines may be used on a case-by-case basis), FDA-approved or compendia supported therapeutic alternatives (with or without PA), for the treatment of patient's condition; **OR**

	b. Requested agent is refill protected under RCW 69.41.190 (1)(a) and all the following are met: i. Patient received the same active ingredient as the requested agent within the last 30 days; **AND** ii. Patient is not continuing therapy based off being established on samples, manufacturer coupons, or otherwise; **AND** iii. Drug is in a refill protected AHPDL drug class (see Table 1). If ALL criteria are met, the request may be authorized up to **12 months.**
	Criteria (Reauthorization) Drugs may be approved when all the following documented criteria are met: 1. Patient is not continuing therapy based off being established on samples, manufacturer coupons, or otherwise. If they have, initial policy criteria must be met for the patient to qualify for renewal evaluation through this health plan; AND 2. Documentation within the last 12 months is submitted demonstrating disease stability or a positive clinical benefit. If ALL criteria are met, the request may be reauthorized up to **12 months.**

References

*Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/

Table 1: Refill Protected AHPDL Drug Classes

All AHPDL drug classes that fall within the therapeutic classes listed below apply

Refill Protected AHPDL Drug Classes
ADHD / ANTI-NARCOLEPSY : NON-STIMULANTS
ADHD / ANTI-NARCOLEPSY : STIMULANTS
ANTICONVULSANTS
ANTIDEPRESSANTS
ANTIPSYCHOTICS / ANTIMANIC AGENTS
HIV
IMMUNOSUPPRESSIVE AGENTS TO PREVENT ORGAN REJECTION POST TRANSPLANT
ONCOLOGY AGENTS

History

Approved Date	Effective Date	Version	Action and Summary of Changes
10/21/2025	2/1/2026	NC 0002-1	New non-clinical policy