Clinical Guideline

Oscar Clinical Guideline: Continuity of Care California (PG131-REG, Ver. 2)

Continuity of Care California

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

This policy is established with the intent of providing coverage for prescription drugs in compliance with the California Health and Safety Code 1367.22 regulatory requirement for drugs previously approved for coverage by the Plan. This policy applies to prescription drugs that are previously approved by the FDA and are currently marketed in the United States. Prescription drugs that are covered under this policy will be subject to the same Cost Share requirements as other covered services.

Definitions

"**Approved for Coverage"** refers to payment for a prescription drug by the Plan for medications prescribed by a medical practitioner for the treatment of a diagnosed medical condition.

"**Brand Name Drug**" means the first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

"**Compendia**" are summaries of drug information and medical evidence to support decision-making about the appropriate use of drugs and medical procedures. Examples include, but are not limited to:

1. American Hospital Formulary Service Drug Information
2. Clinical pharmacology
3. National Comprehensive Cancer Network Drugs and Biologics Compendium
4. Thomson Micromedex DrugDex
5. United States Pharmacopeia-National Formulary (USP-NF)

"**Cost Share**" means the amount which the Member is required to pay for Covered Services. Where applicable, Cost Shares can be in the form of Copayments, Coinsurance and/or Deductibles.

"**FDA**" means the Federal Food and Drug Administration.

"**Formulary**" means the list of covered pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

"**Generic Drugs**" means prescription Drugs that have been determined by the Food and Drug Administration (FDA) to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (e.g., tablet, capsule, cream) as the Brand Name Drug.

"**Plan's Provider Network**" refers to the group of healthcare providers and facilities that have contracted with the Plan to provide medical services to the plan's members.

"**Prescription Drug Coverage**" refers to medical insurance coverage for medications prescribed by a medical practitioner for the treatment of a diagnosed medical condition.

Coverage Criteria

The requested drug will be covered with prior authorization when the following criteria are met:

1. The requested drug is being prescribed by a prescriber within the Plan's Provider Network***; AND***

   [Note: Medical or Pharmacy Network, for drugs that can be prescribed by a pharmacist.]
2. The requested drug has been dispensed at a pharmacy and approved for coverage by the Plan previously***; AND***
3. The requested drug is being prescribed for an FDA-approved indication***; AND***
4. The requested drug is being appropriately prescribed and is considered safe and effective for treating the patient's medical condition based on FDA-approved regimen (i.e., dosing and treatment duration)***; AND***
5. If the request is for a Brand name product that has a generic equivalent on the Plan's Formulary, the patient had a trial and failure of the generic equivalent due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient.

If the above prior authorization criteria are met, the requested medication may be approved for up to 12 months.

Experimental or Investigational / Not Medically Necessary

The use of drugs and biologicals for any indication that is not supported by the FDA or compendia is considered not medically necessary by the Plan, as it is deemed to be experimental, investigational, or unproven.

References

1. California Health and Safety Code 1367.22. (Amended by Stats. 2002, Ch. 760, Sec. 2. Effective January 1, 2003.)

Clinical Guideline Revision / History Information

Original Date: 02/24/2023 Reviewed/Revised: 06/01/2023