Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: **Compound Medications**

Effective: September 12, 2023

Guideline Type	☐ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☒ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Pharmaceutical compounding is the combining, mixing, or altering of ingredients to create a customized medication that is not otherwise commercially available. The Food and Drug Administration (FDA) does not allow the marketing of compounded drugs that were withdrawn or removed from the market due to lack of safety or effectiveness; or compounding finished drugs from bulk active ingredients that are not per FDA regulations; or compounding drug products that are commercially available or that are essentially copies of commercially available FDA-approved drug products.

Please note, compounded prescription claims may process for patients under the age of 18 for those compounds with active ingredients on formulary.

Clinical Guideline Coverage Criteria

For those compounds prescribed for members 18 years of age or older or exceed $500 per claim, the plan may authorize coverage when ALL of the following criteria are met:

Initial Therapy:

Request is for one of the following:

1. Magic mouth wash
2. All-purpose nipple ointment (APNO) consisting of betamethasone, clotrimazole, and mupirocin
3. Medication indicated for fertility or maintenance of pregnancy

OR

Compound containing Melatonin or Nutritional supplements used for a mitochondrial disorder or for a mitochondrial cocktail

1. The requested compound is for a patient 17 years of age or younger

AND

2. Request is for a compound containing ONE of the following:
   a. Nutritional supplements used for a mitochondrial disorder or for a mitochondrial cocktail
   b. Melatonin

OR

Other compound medication requests

1. All of the following:
    a. For the condition being treated, each of the active ingredients in the compound are FDA-approved or supported by a nationally recognized compendium

    AND

    b. The therapeutic amounts are FDA-approved or supported by a nationally recognized compendium for the condition being treated in the requested route of delivery

    AND

    c. The route of administration for the compound is FDA approved or supported by a nationally recognized compendium for the condition being treated

    AND

2. All of the active ingredients included in the compound are FDA-approved

    AND

3. If there are existing clinical coverage criteria for any of the active ingredients, those criteria will also need to be met for these ingredients

    AND

4. The requested compound is NOT for a cosmetic use

    AND

5. One of the following:
    a. There is a current supply shortage of the commercial product

    OR

    b. The patient has a medical need for a dosage form or dosage strength that is not commercially available

    OR

    c. The patient had a trial and intolerance to or contraindication to the commercially available product (e.g. allergen/preservative/dye-free, palatability for pediatrics, adverse effects to binders/fillers/other active ingredients)

    OR

    d. The commercial product has been discontinued by the pharmaceutical manufacturer for reasons other than lack of safety or effectiveness

    OR

Reauthorization:

1. Requested medication is a renewal

    AND

2. The patient has experienced improvement while on therapy

Note: All of the active ingredients included in the compound need to be included on the request for authorization.

Limitations

- Approval for compound medications will be authorized for 12 months except for the following:
    - Compounds containing melatonin or nutritional supplements used for a mitochondrial disorder or for a mitochondrial cocktail will be approved until the patient reaches their 18th birthday
    - Compound medication due to supply shortages will be authorized for three (3) months
- For reauthorization requests, the plan requires evidence of utilization within the past 365 days per patient's claim profile otherwise initial criteria will be applied.
- Coverage is not provided in situations where the compound is intended for cosmetic use (e.g. anti-aging, anti-wrinkle, hair growth/removal, scar diminishing, skin lightening/tanning) OR performance enhancement. Examples include but are not limited to:
    - Arginine used for exercise performance
    - Chorionic gonadotropin (HCG) used for performance enhancement or anti-aging
    - Clomiphene used for performance enhancement or anti-aging
    - Coenzyme Q10 (ubiquinol / ubidecarenone) used for performance enhancement
    - Testosterone used for performance enhancement

- For a non-formulary medication request, please refer to the Pharmacy Medical Necessity Guidelines for Formulary Exceptions and submit a formulary exception request to the plan as indicated.

Codes

None

References

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7. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed June, 2014.
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10. National Institutes of Health (2020). Dietary Supplements for Primary Mitochondrial Disorders Available at: https://ods.od.nih.gov/factsheets/PrimaryMitochondrialDisorders-HealthProfessional/. Accessed Aug 2022.

Approval And Revision History

September 2022: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- October 2022 e-vote: Updated criteria to include magic mouthwash, APNO, and medications indicated for fertility or maintenance of pregnancy. Clarified cosmetic uses and reauthorization criteria. Updated guideline type to administrative.
- September 12, 2023: No changes.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.