MEDICATION POLICY

Generic Name: Brand Name Medication

Therapeutic Class or Brand Name: Brand Name Medication

Applicable Drugs (if Therapeutic Class)**:**

Policy may apply to any brand name medication that has a generic therapeutic equivalent available.

Date of Origin: 2/1/13 **Date Last Reviewed/Revised:** 1/4/18

GPI Code: Various

Prior Authorization Criteria (may be considered medically necessary when criterion I is met):

I. Patient has a physician evaluated, charted documentation of an allergic reaction or adverse reaction to a generic therapeutic equivalent. Patient complaints of lack of efficacy are not acceptable reasons for failure such as "Client said", "client reports", "doesn't work", or "causes nausea". The following A and B must be provided:

A. Details as to why a generic therapeutic equivalent is not appropriate or is contraindicated.

B. Explanation of why treatment with the specific branded product is necessary.

Exclusion Criteria:

- N/A

Other Criteria:

- Many extended-release branded products do not have extended-release generic equivalents. In these cases, an adequate trial of the short-acting generic product is required.
- Some brand name dosage forms may not have the same dosage form available in a generic therapeutic equivalent. In these cases, an adequate trial of the other available dosage forms of the generic theapeutic equivalent is required.

Quantity/Days Supply Restrictions:

- Quantity/Days Supply Restrictions may apply.

Approval Length:

- **Authorization:** 1 year.

- **Re-Authorization:** An updated letter of medical necessity or progress notes showing the medication is effective.

Appendix:

N/A

References:

1. https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/BrandNameMedication.pdf.

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Historical Tracking Of Changes Made To Policy	
1/4/2018	1. Policy reviewed: no changes made.
10/9/2016	1. Policy reviewed: no changes made.
8/20/2015	1. **Changed** "See attached "Brand Name Medications Requiring Therapeutic Equivalent Generics First" list. Policy may also apply to other medications not listed" **to** "Policy may apply to any brand name medication that has a generic therapeutic equivalent available" **under Applicable Drugs**. 2. **Changed Appendix from** "See attached "Brand Name Medications Requiring Therapeutic Equivalent Generics First" list" **to** "N/A". 3. **Deleted "Brand Name Medications Requiring Therapeutic Equivalent Generics First" list**. 4. **Updated** "http://www.health.utah.gov/medicaid/pharmacy/priorauthorization/pdf/Brand_Name_Medication.pdf." **to** "https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/BrandNameMedication.pdf" **under References**.
12/10/2013	1. **Adapted policy to new format.** 2. **Added** "Various" **to GPI Code**. 3. **Changed Prior Authorization Criteria from:** "Prior Authorization Criteria: Details as to why a generic therapeutic equivalent is not appropriate or is contraindicated AND Explanation of why treatment with the specific branded product is necessary; Covered Uses: Prior authorizations for brand name medications require physician evaluated, charted documentation of an allergic reaction or adverse reaction. Patient complaints of lack of efficacy are not acceptable reasons for failure such as "Client said", "client reports", "doesn't work", or "causes nausea"" **to:** "Patient has a physician evaluated, charted documentation of an allergic reaction or adverse reaction to a generic therapeutic equivalent. Patient complaints of lack of efficacy are not acceptable reasons for failure such as "Client said", "client reports", "doesn't work", or "causes nausea". The following A and B must be provided: A. Details as to why a generic therapeutic equivalent is not appropriate or is contraindicated, B. Explanation of why treatment with the specific branded product is necessary". 4. **Changed Re-Authorization under Approval Length from** "Updated letter of medical necessity" **to** "An updated letter of medical necessity or progress notes showing the medication is effective". 5. **Added** "Aczone® (dapsone), Armour® Thyroid (thyroid), Bactroban® (mupirocin), Boniva® (ibandronate), Cipro® (ciprofloxacin), Cipro® XR (ciprofloxacin), Colcrys® (colchicine), Coumadin® (warfarin), Lanoxin® (digoxin), Levothroid® (levothyroxine), Levoxyl® (levothyroxine), Plavix® (clopidogrel), Prevpac® (lansoprazole/amoxicillin/clarithromycin), Sonata® (zaleplon), Synthroid® (levothyroxine)" **to the "Brand Name Medications Requiring Therapeutic Equivalent Generics First" list**. 6. **Removed** "Alphagan-P® (brimonidine), Prevacid (lansoprazole), Prevacid® SoluTab (lansoprazole), Prevacid® Solution (lansoprazole), Prevacid® 24HR (lansoprazole), Protonix® (pantoprazole)" **to the "Brand Name Medications Requiring Therapeutic Equivalent Generics First" list**.