PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCRP4064</td><td colspan="2">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Continuation of Prescription Drugs</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/06/2017</td><td colspan="3">Next Review Date: 08/12/2027
Last Review Date: 08/12/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☒ P & T</td><td colspan="2">☐ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 08/12/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCRP4068 Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

A. Member Services

B. Grievance and Appeals

III. DEFINITIONS:

A. Prescribing provider: a provider authorized to write a prescription to treat a medical condition of a member.

B. Medi-Cal Rx: On January 7, 2019, Governor Gavin Newsom issued Executive Order N-01-19 (EO-N-01-19) for achieving cost-savings for drug purchases made by the state. A key component of EO N-01-19 requires the Department of Health Care Services (DHCS) transition all Medi-Cal pharmacy services from managed care (MC) to fee for service (FFS), which was implemented as Medi-Cal Rx on January 1, 2022.[1]

C. Physician-Administered Drug (PAD) or Medical Benefit Medications: A physician-administered drug is an outpatient drug that is typically administered by a health care provider in a physician's office or other outpatient clinical setting. For example, drugs that are infused or injected are typically physician-administered drugs. The provider bills the appropriate state Medicaid program (fee for service, managed care plan, or county operated health system) for the drug using the appropriate national drug code (NDC) and Healthcare Common Procedure Coding System (HCPCS) code.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the conditions under which medications may be continued for coverage of a medical condition for members newly enrolled in benefits under Partnership HealthPlan of California (PHC) and when administered by a plan provider in accordance with the Welfare and Institutions Code 14185 (b, provided that the drug is appropriately prescribed and is considered safe and effective for treating the member's medical condition, including for new Members who were previously receiving the medication when medically necessary and safe. This policy applies to the processing of medical claims for PAD as outlined in policy MCRP4068 Medical Benefit Medication TAR Policy.

[1] This policy applies only to physician-administered drugs under the medical benefit and does not apply to outpatient prescription drugs under Medi-Cal Rx.

Policy/Procedure Number: MCRP4064			Lead Department: Health Services
Policy/Procedure Title: Continuation of Prescription Drugs			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/06/2017		**Next Review Date: 08/12/2027** **Last Review Date: 08/12/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VI. POLICY / PROCEDURE:

Nothing in this policy shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the member, nor shall anything in this section be construed to prohibit generic drug substitutions.

A. This policy does not apply to coverage determinations for drugs prescribed for uses not approved for marketing by the federal Food and Drug Administration (FDA), otherwise known as "off-label" use. However, coverage for off-label-use drugs shall be evaluated in accordance with applicable Medi-Cal requirements, including Section 1927(k)(2) of the Social Security Act and CA Health & Safety Code Section 1367.2, and remains subject to Partnership MCRP4068 - Medical Benefit Medication TAR Policy.

B. This policy shall not be construed to restrict or impair the application of any other Partnership policy including its requirement that the plan furnish services in a manner providing continuity of care and demonstrating that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management.

C. New start designation in Treatment Authorization Request (TAR) Criteria:
   1. A new start is a Partnership member who has not previously been on the drug in question. A member who has been previously on a medication but with a significant lapse in treatment may be interpreted as a new start when the duration without the medication indicates the member has not been dependent upon it for treatment and the current request actually represents a restart of treatment rather than continuing treatment.
   2. A new member may also be considered a new start, in the sense that Partnership has not previously paid for the medication. Care must be exercised if the member was previously on the drug through a *state funded program* (Medi-Cal FFS or another Managed Care Medi-Cal/COHS), as it may be prudent to continue a medication the member previously had prior authorization for under a different *state* payer.

D. Continuing care requests for existing Partnership members with claim history and previously approved Partnership TARs:
   1. Drugs with previous Partnership criteria undergoing *new start criteria revision*: members with previously approved Partnership TARs for ongoing use which have been administered in a clinical setting routinely without significant stops/breaks in therapy will be allowed to continue ongoing treatment when indicated (*i.e.*, will not have to meet revised criteria unless treatment is deemed a restart rather than continuation). This will also apply to drugs not on the Covered Medical Drug List with *new TAR criteria*, which have always not been on the Covered Medical Drug List (but without TAR criteria).
   2. Drug Criteria in which renewal criteria are revised or initiated, renewals will be considered in terms of any requirements for additional documentation or maximum durations of therapy, based on clinical references/compendia recommendations, in order to document safety and efficacy of continued treatment.
   3. Negative Changes: Since many PAD drugs are used for acute or limited duration, this section applies to maintenance or cyclical treatment drugs that would be used in an ongoing manner, such as chemotherapy, IV infusions for multiple sclerosis, rheumatoid arthritis, and all other disease treatments that require ongoing treatment with a medication affected by a negative change. All negative changes approved by the P&T committee will also include approval of a continuation of care management plan based on that drug's unique properties and consistent with this policy.
      a. Addition of Prior Authorization requirement to a drug previously reimbursable without a PA: Configuration Department issues a IPN (Important Provider Notice), which is posted on the Partnership Claims/Provider web pages, and affected Members shall be notified consistent with Medi-Cal grievance and appeal requirements. Partnership will identify those members who have

had recent ongoing claims (within a lookback period appropriate for the dosing frequency of the drug) and inform those members that prior authorization may be required for future service.

b. Members currently receiving the medication shall not experience interruption of therapy during the prior authorization (TAR) review process.

c. Addition of billing requirements (ICD-10) or limitations (age, dose, frequency): When a drug code was previously reimbursable without any requirements or limits, and such have been added, Partnership will identify those members who have had recent ongoing claims not meeting the new requirements or limitations (within a lookback period appropriate for the dosing frequency of the drug), and inform those members that new requirements &/or limits have been added, which may affect future provider claim reimbursement.

E. Continuing care for California Children's Services (CCS)-eligible members transitioning to Partnership:

1. Pursuant to State of California DHCS All Plan Letter (APL) 21-005, CCS-eligible members transitioning into Partnership Whole Child Model program are allowed continued use of any currently pharmaceutical drug therapy that is part of their medical treatment for the CCS-eligible condition. The CCS-eligible member must be allowed to continue receiving the physician administered drug therapy without interruption until Partnership and the ordering physician agree that the particular drug is no longer medically necessary or is no longer going to be administered by the county CCS program provider.

VII. REFERENCES:

A. State of California Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015, California Children's Services Whole Child Model Program (12/2/24 supersedes 23-034)

B. DHCS APL 22-012, Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (*revised* 12/30/22 supersedes 20-020)

C. SSA 1927(k)(2): Definition of Covered Outpatient Drugs

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director, Pharmacy Services

X. REVISION DATES:

*01/18/18; 11/14/18; 05/08/19; 02/12/20; 05/12/21; 05/11/22; 8/9/23; 08/14/24; 08/13/25, 8/12/26

*Through 2017, Approval Date reflective of the Pharmacy & Therapeutics Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

N/A

XI. POLICY DISCLAIMER:

A. In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

1. Consistent with sound clinical principles and processes;
2. Evaluated and updated at least annually;
3. If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or member upon request.

B. The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.
C. Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.