LifeWise
Health Plan of Washington

PHARMACY / MEDICAL UTILIZATION MANAGEMENT GUIDELINE– 5.01.607

Continuity of Coverage for Maintenance Medications

Effective Date:	Dec. 1, 2024	RELATED POLICIES / GUIDELINES:
Last Revised:	Nov. 12, 2024	None
Replaces:	N/A	

COVERAGE GUIDELINES | CODING | RELATED INFORMATION | REFERENCES | HISTORY

Clicking this icon returns you to the hyperlinks menu above.

Introduction

When people switch from one health insurance plan to another, the maintenance medications they take may need to be covered by the new health plan. This is known as continuing coverage of maintenance medications. This may also occur when there are new medication restrictions for current members. In general, the plan could continue covering maintenance medications as long as that medication is working, is needed to maintain health, is covered by the member contract, and switching to a different but similar medication would cause health disruptions. This policy discusses when continuing coverage of maintenance medications may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Coverage Guidelines

Click on the links below to be directed to the related medical necessity criteria:

New to Plan Member: Drug Has a Preferred Generic or Biosimilar Alternative

New to Plan Member: Drug Does NOT Have a Preferred Generic or Biosimilar Alternative

Current Member: Drug Has a Preferred Generic or Biosimilar Alternative

Current Member: Drug Does NOT Have a Preferred Generic or Biosimilar Alternative

Requested Exception	Medical Necessity
Continuation of a maintenance medication for new to plan members for a drug that DOES have a preferred generic or biosimilar alternative	**Policy 5.01.607 criteria are utilized when the member does NOT meet the standard Medical Policy criteria for medication.** **Continuation of a maintenance medication that a member has been receiving with insurance coverage from another health plan that DOES have a preferred generic or biosimilar alternative may be considered medically necessary when ALL the following conditions are met:** • The individual has been continuously receiving the medication for ≥ 90 days and is stable on the current regimen **AND** • Medication is not for experimental or investigational use **AND** • Coverage of the medication is not excluded in the member's contract **AND** • *Is **NOT** receiving the medication from manufacturer supplied samples from the prescriber or using the manufacturer's coverage coupons as a means to establish the member as a current user of the medication **AND** • The prescriber is requesting the medication due to a DOCUMENTED adverse reaction, allergy, or sensitivity to ALL preferred generic or biosimilar alternatives **OR** • The prescriber is requesting the medication due to a DOCUMENTED trial of at least 3 months and therapeutic failure with ALL preferred generic or biosimilar alternatives **Note:** The prescriber should submit the standard prior authorization request for all medications. Requests that clearly meet the standard prior authorization coverage criteria will be routinely approved.

Requested Exception	Medical Necessity
	Note: *With the increasing cost of prescription medications and concerns regarding abuse and diversion, the use of manufacturer supplied samples given to the individual by a provider is decreasing. Recently, this practice is being replaced with manufacturer coupons and other special assistance programs that either provide full coverage for a trial period of the medication or provide copay assistance to the member. While these programs have valid uses, they can be used to circumvent payer restrictions and establish an individual on therapy for which they would otherwise not qualify.

Continuation of maintenance medication for new to plan members for a drug that DOES NOT have a preferred generic or biosimilar alternative	**Policy 5.01.607 criteria are utilized when the member does NOT meet the standard Medical Policy criteria for medication.**
	
	Continuation of a maintenance medication that a member has been receiving with insurance coverage from another health plan that DOES NOT have a preferred generic or biosimilar alternative may be considered medically necessary when ALL the following conditions are met:
	• Individual has been continuously receiving the medication for ≥ 90 days and is stable on the current regimen
	AND
	• Medication is not for experimental or investigational use
	AND
	• Coverage of the medication is not excluded in the member's contract
	AND
	• Switching to a therapeutic alternative medication that is preferred on the member's new formulary may cause a predictable adverse clinical outcome and documentation is provided on why an adverse clinical outcome would be expected such as:
	  ○ The condition has been difficult to control (e.g., many medications tried, multiple medications required to control condition, etc.)
	  ○ The individual had a significant adverse outcome when the condition was not controlled previously (e.g., hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering, etc.)

Requested Exception	Medical Necessity
	AND • *Is **NOT** receiving the medication from manufacturer supplied samples from the prescriber or using the manufacturer's coverage coupons as a means to establish the member as a current user of the medication **Note:** The prescriber should submit the standard prior authorization request for all medications. Requests that clearly meet the standard prior authorization coverage criteria will be routinely approved. **Note:** *With the increasing cost of prescription medications and concerns regarding abuse and diversion, the use of manufacturer supplied samples given to the individual by a provider is decreasing. Recently, this practice is being replaced with manufacturer coupons and other special assistance programs that either provide full coverage for a trial period of the medication or provide copay assistance to the member. While these programs have valid uses, they can be used to circumvent payer restrictions and establish an individual on therapy for which they would otherwise not qualify.
Continuation of a maintenance medication for current plan members for a drug that DOES have a preferred generic or biosimilar alternative	**Policy 5.01.607 criteria are utilized when the member does NOT meet the standard Medical Policy criteria for medication.** **Continuation of a maintenance medication that a current plan member has been receiving prior to the implementation of new or revised utilization management restrictions for a drug that DOES have a preferred generic or biosimilar alternative may be considered medically necessary when ALL the following conditions are met:** • Individual has been continuously receiving the medication for ≥ 90 days and is stable on the current regimen **AND** • Medication is not for experimental or investigational use **AND** • Coverage of the medication is not excluded in the member's contract **AND** • Individual or the prescriber has **NOT** received a notification from the plan documenting that the member is subject to

Requested Exception	Medical Necessity
	review for the new or revised utilization management restriction **AND** • * Is **NOT** receiving the medication from manufacturer supplied samples from the prescriber or using the manufacturer's coverage coupons as a means to establish the member as a current user of the medication **AND** • The prescriber is requesting the medication due to a DOCUMENTED adverse reaction, allergy, or sensitivity to ALL preferred generic or biosimilar alternatives **OR** • The prescriber is requesting the medication due to a DOCUMENTED trial of at least 3 months and therapeutic failure with ALL preferred generic or biosimilar alternatives **Note:** The prescriber should submit the standard prior authorization request for all medications. Requests that clearly meet the standard prior authorization coverage criteria will be routinely approved. **Note:** *With the increasing cost of prescription medications and concerns regarding abuse and diversion, the use of manufacturer supplied samples given to the individual by a provider is decreasing. Recently, this practice is being replaced with manufacturer coupons and other special assistance programs that either provide full coverage for a trial period of the medication or provide copay assistance to the member. While these programs have valid uses, they can be used to circumvent payer restrictions and establish an individual on therapy for which they would otherwise not qualify.
Continuation of a maintenance medication for current plan members for a drug that DOES NOT have a preferred generic or biosimilar alternative	**Policy 5.01.607 criteria are utilized when the member does NOT meet the standard Medical Policy criteria for medication.** **Continuation of a maintenance medication that a current plan member has been receiving prior to the implementation of new or revised utilization management restrictions that DOES NOT have a preferred generic or biosimilar alternative may be considered medically necessary when ALL the following conditions are met:**

Requested Exception	Medical Necessity
	• Individual has been continuously receiving the medication for ≥ 90 days and is stable on the current regimen **AND** • Medication is not for experimental or investigational use **AND** • Coverage of the medication is not excluded in the member's contract **AND** • Individual or the prescriber has **NOT** received a notification from the plan documenting that the member is subject to review for the new or revised utilization management restriction **AND** • *Is **NOT** receiving the medication from manufacturer supplied samples from the prescriber or using the manufacturer's coverage coupons as a means to establish the member as a current user of the medication **Note:** The prescriber should submit the standard prior authorization request for all medications. Requests that clearly meet the standard prior authorization coverage criteria will be routinely approved. **Note:** *With the increasing cost of prescription medications and concerns regarding abuse and diversion, the use of manufacturer supplied samples given to the individual by a provider is decreasing. Recently, this practice is being replaced with manufacturer coupons and other special assistance programs that either provide full coverage for a trial period of the medication or provide copay assistance to the member. While these programs have valid uses, they can be used to circumvent payer restrictions and establish an individual on therapy for which they would otherwise not qualify.

Length of Approval	
Approval	**Criteria**
Initial authorization	**A medication approved under this policy will be approved following the re-authorization criteria and approval duration as listed in the reference Medical Policy for medication.**

Length of Approval	
Approval	**Criteria**
Re-authorization	**Future re-authorization will follow the re-authorization criteria and approval duration as listed in the reference Medical Policy for medication.**

Documentation Requirements
The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following: • Office visit notes that contain the diagnosis, relevant history, physical evaluation, medication history, and any prior medication related adverse events

Coding

N/A

Related Information

Rationale

Copay Coupons Are a Marketing Tool

Pharmaceutical manufacturers' attempts to circumvent the restrictions on access that managed care and pharmacy benefit managers present for their drugs has resulted in a widely used marketing tool: the copay card or coupon. These tools reimburse individuals who have prescription-drug coverage for the cost of their copay if they choose the higher-priced brand drug instead of that preferred by their plan sponsor.

At one time, a drug's commercial success or failure was largely driven by how well it was received by physicians. Pharma marketers primarily targeted physicians. But then drug makers found that aggressive direct-to-consumer campaigns could more effectively influence prescription-writing, and their focus shifted to individuals. But starting in the late 1990s, another transition began. Today, the commercial success of a drug is largely driven by access to

individuals, and controlling that access are entities such as managed-care plans and pharmacy benefit managers (PBMs). Pharmaceutical marketers have sought to regain that control by using the coupons to neutralize the financial incentives that plans use to encourage the use of clinically equivalent but lower-priced medications, chiefly generics.

How Copay Coupons Contribute to Pharmacy Waste

Copay coupons inject waste into the healthcare system. In 2011, the Pharmaceutical Care Management Association estimated that copay coupons will increase 10-year prescription-drug costs by $32 billion if current trends continue. Many individuals don't consider the extra cost to the system when offered a chance to reduce their copay, and that this temporary savings may ultimately contribute to higher premiums or fewer benefits.[1]

Coupons undermine the payer's ability to use different copay amounts to reduce drug costs. They are widely available to consumers through the Internet, television, magazines, and e-mail offers. This tactic was developed over the past decade as large pharmaceutical manufacturers lost patent protection on key branded products. By using a coupon to neutralize the copay differential, individuals could stay on the brand they are familiar with.

More recently, manufacturers have introduced very high-cost new drugs where the coupon may cover hundreds or even thousands of dollars per month, though this may still be less than half the total prescription cost. In turn, manufacturers have to increase drug prices to cover the cost of the coupons, and since they normally require that the individual have health insurance that is not paying the full cost, they offer no benefit to the poor and uninsured, who not only have to pay the full price, but also shoulder the burden imposed by the price increases. This becomes a moral hazard when coverage is limited to those with insurance.[2] Coupons are banned in Medicare and Medicaid programs based on the federal anti-kickback statute and are partially banned in the Commonwealth of Massachusetts.

References

1. Neville E. The dark side of copay coupons.
2. Liday C, Pannier A. The cost of free: The impact of prescription copay coupons on the healthcare system.
3. National Consumers' League. Looking for ways to save on Rx Meds? Co-pay cards and other resources. Available at: **https://www.nclnet.org/co-pay_cards** Accessed August 26, 2024.

4. Consumer Reports. Don't get hooked on prescription drug coupons. They aren't always what they seem to be. March 2012. Available at: **http://www.consumerreports.org/cro/2012/03/don-t-get-hooked-on-prescription-drug-coupons/index.htm** Accessed August 26, 2024.

History

Date	Comments
07/14/15	New Utilization Management Guideline, add to Prescription Drug section. Continuation of certain maintenance medications that a member has been receiving with insurance coverage from another health plan may be considered medically necessary when conditions are met.
05/01/17	Annual Review, changes approved April 11, 2017. No changes are necessary at the time of this policy revision. Policy criteria and guidelines are up to date.
10/24/17	Guideline moved to new format, no changes to guideline statement.
06/01/18	Annual Review, approved May 3, 2018. No changes made.
05/01/19	Annual Review, approved April 18, 2019. No changes made.
02/01/20	Annual Review, approved January 9, 2020. Removed reference to "at no cost" for prescriber samples and "free trial" in coupon description.
05/01/21	Annual Review, approved April 13, 2021. Updated criteria for new to plan member adding a 90-day minimum requirement for continuous use of maintenance medication and requiring documentation that switching the patient to a therapeutic alternative medication that is preferred may cause a predictable adverse clinical outcome for patient. Added criteria for continuation of maintenance medications for current plan member.
10/01/22	Annual Review, approved September 13, 2022. Added criteria that Policy 5.01.607 is utilized when the member does NOT meet the standard Medical Policy criteria for medication. Updated criteria for continuation of maintenance medications for current plan member to include the member's prescriber and changed letter to notification from the plan.
06/01/23	Annual Review, approved May 22, 2023. No changes to policy statements.
09/01/24	Annual Review, approved August 12, 2024. No changes to policy statements.
12/01/24	Interim Review, approved November 12, 2024. Added coverage criteria for continuation of a maintenance medication for new to plan members for a drug that does have a preferred generic or biosimilar alternative. Added coverage criteria for continuation of a maintenance medication for current plan members for a drug that does have a preferred generic or biosimilar alternative.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.