**Original Effective Date: 12/11/2013**
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**Next Review Due By: 10/2026**
**Policy Number: C4141-A**

# Off-Label Use of Drugs and Biologic Agents

## PRODUCTS AFFECTED

## COVERAGE POLICY

*Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.*

***Documentation Requirements:***
*Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.*

**DIAGNOSIS:**
N/A

**POSITION STATEMENT**

- Molina Healthcare Inc. Prior Authorization Criteria or Molina Clinical Policy (MCP) criteria or drug-specific approved policies take precedence over the criteria in this policy; hence these drug- specific policies must be reviewed **prior** to applying the criteria in this policy.
- This policy should only be applied when there is no Molina Healthcare Inc. Prior Authorization Criteria or MCP or drug-specific policy addressing the requested **off-label use** of an FDA- approved drug.
- This policy shall not be interpreted to require coverage for any drug or biological agent when the FDA has determined its use to be contraindicated. Molina Healthcare will evaluate each request for an unlabeled use of any drug on a **case-by-case basis.**
- The FDA approves drugs for specific indications that are included in the drug's labeling. When a drug is used for an indication, dose, age and/or duration other than those specifically included in the labeling, it is referred to as an off-label use.
- FDA indication alone does **not** establish the medical necessity of a particular drug for a particular patient. Molina Healthcare reserves the right to review all treatments for their clinical

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appropriateness.

- If there is a discrepancy between this policy and the plan of benefits, the provisions of the member's benefits plan will govern.
- Accepted Standard of Medical Practice: Acceptance by individual health care practitioners, or even a limited group of health care practitioners, does not translate to general acceptance by the medical community. Testimonials, recommendations, and declarations indicating such limited acceptance and limited case studies are **not** sufficient evidence of general acceptance by the medical community.

**REQUIRED MEDICAL INFORMATION:**
**NOTE: PRIOR TO ANY REVIEW FOR EXCEPTION REVIEWER SHOULD VERIFY THERAPY ELIGIBILITY FOR BENEFIT EXCLUSION OR CARVE OUT STATUS**
*This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review.*

A. ALL INDICATIONS:
In the absence of drug/drug class specific Molina Healthcare Inc. Prior Authorization Criteria or Medical Clinical Policy addressing the requested off-label use of the drug or biologic, requests will be reviewed on a case-by-case basis.

1. Requested drug has been approved as safe and effective by the U.S. Food and Drug Administration (FDA) for at least ONE indication
   MOLINA REVIEWER NOTE: For California Medicaid, please see Appendix.
   AND
2. (a) Documentation the member's condition is severe enough (as shown by a relevant scoring tool) to require pharmacologic intervention as determined by the applicable guidelines or compendia
   OR
   (b) Prescribed for the treatment of a life-threatening, chronic, and seriously debilitating conditions as defined by ONE of the following:
   i. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted OR Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival OR
   ii. Diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause serious long-term morbidity
   AND
3. Documentation member has tried and failed, or has a contraindication to, the FDA labeled alternatives for the member's diagnosis
   AND
4. Documentation member has tried and failed, or has a contraindication to, the treatment guideline recommended formulary alternatives which are considered to be standard of care and which are of equal or greater efficacy compared to the requested agent for the member's diagnosis
   AND
5. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review AND the requested drug is not contraindicated by the FDA for the off-label use prescribed
   AND
6. Prescriber attests to baseline and ongoing safety monitoring per FDA label for the requested drug
   AND
7. Documentation that the requested drug, dose, frequency, and duration is supported for treatment

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of the member's diagnosis and age as shown by ONE of the following:

a) Documented as appropriate for the stated usage by ONE of the following CMS-approved drug compendia:
NOTE: The complete absence of narrative text on a use is considered neither supportive nor non- supportive.
   i. Elsevier Gold Standard's Clinical Pharmacology: The narrative text is supportive of the requested off-label use and noted as a 'Strong Recommendation.' Recommendations noted as 'Equivocal/Weak' are not considered supportive of an off-label indication.
   OR
   ii. American Hospital Formulary Service-Drug Information (AHFS-DI): The narrative text in AHFS-DI) is supportive of the requested off-label use. NOTE: The "dagger" symbol is used to indicate off-label drug use by the American Hospital Formulary Service Drug Information® (AHFS®, Bethesda, MD). If AHFS indicates an off-label use but qualifies that statement with "but additional study is needed" or "further study is needed to evaluate safety and efficacy", the qualifying language does not support an off-label indication as medically necessary. Refer to Appendix 2 for AHFS Levels of Evidence Rating System.
   OR
   iii. National Comprehensive Cancer Network Compendium (NCCN): MHI recognizes Category 1 and 2 A approvals
   iv. Micromedex DrugDex: MHI recognizes Class I and IIa strength of recommendation.

OR

b) Prescriber submitted copies of relevant full-text articles from at least two (2) major peer-reviewed journals* **providing evidence of both safety and efficacy** for the off-label requested use and meets ALL of the following:
   i. Phase III randomized, placebo-controlled studies with subject size sufficient to determine statistical validity [Published studies required] or An adequate number of well-designed studies with sufficient numbers of subjects in relation to the incidence or prevalence of the disease
   NOTE: *Peer-Review Medical Literature: Off-label uses that are supported by clinical research peer-reviewed medical literature that may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
   Molina Healthcare considers any drug being studied in a phase I or phase II clinical trial or use that is based solely on evidence from a phase I or phase II clinical trial, investigational. All submitted studies must be published Phase III randomized, placebo-controlled studies with subject size sufficient to determine statistical validity. Refer to Appendix 1: 'Clinical Trial Phases for Investigational New Drugs'.
   MOLINA REVIEWER NOTE: For California Medicaid, please see Appendix.
   AND
   ii. Published in the regular editions of the journals that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity, and reliability.
   NOTE: If ANY of the below are met, evidence is considered insufficient. Articles submitted must not be in the form of:
      - A special supplement or publication and not to include publications privately funded by parties (i.e., manufacturers of the product) with a vested interest in the recommendations and provides full disclosure of any conflict of interest or biases for all authors, contributors, or editors associated with the journal or organization
      - In-house publications by pharmaceutical manufacturing companies or abstracts (including meeting abstracts) are not considered peer review medical literature
      - Retrospective studies, opinion statements, *case reports, letters to the editor, abstracts of a publication, reports of Phase I or Phase II trials are not sufficient. *In general, case reports are considered uncontrolled, are based on anecdotal information, and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

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AND

8. The requested drug, dose, frequency, and duration for treatment of the member's diagnosis and age is NOT identified as unsupported by compendia of current literature (e.g., AHFS, Micromedex, NCCN, current accepted guidelines, etc.)
   AND
9. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal
   AND
10. Prescriber must submit member's medical records and other relevant documentation as deemed necessary by Molina Healthcare to determine if an off-label use is reasonable and necessary for treatment of a member's condition or disease.
    NOTE: It is the responsibility of the prescribing physician to submit to Molina Healthcare documentation supporting the proposed off-label use or uses, as requested. Otherwise, the request may be denied due to inadequate or incomplete information.

**CONTINUATION OF THERAPY:**

A. ALL INDICATIONS:

1. For continuation of therapy of medications for off-label uses for new Molina member: Initial criteria must be met
   AND
2. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
   AND
3. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity
   AND
4. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms [DOCUMENTATION REQUIRED]
   AND
5. Prescriber attests to ongoing safety monitoring per FDA label for the requested drug

**DURATION OF APPROVAL:**

Initial authorization: up to 6 months, Continuation of Therapy: up to 12 months; duration of therapy needs to be supported by evidence provided to support utilization

**PRESCRIBER REQUIREMENTS:**

Prescribed by an appropriate specialist for the indication requested

**AGE RESTRICTIONS:**

Not to exceed limits in compendia or articles provided

**QUANTITY:**

Not to exceed limits in compendia or articles provided

**PLACE OF ADMINISTRATION:**

N/A

## DRUG INFORMATION

**ROUTE OF ADMINISTRATION:**

N/A

**DRUG CLASS:**

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N/A

**FDA-APPROVED USES:**
N/A

**COMPENDIAL APPROVED OFF-LABELED USES:**
N/A

## APPENDIX

**APPENDIX:**
***Reserved for State specific information.*** *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

***State Specific Information***
**State Medicaid**
**California** (Source: California Code of Regulations, California Code of Regulations)
"Cal. Code Regs. Tit. 22, § 51303 - General Provisions
(g) Experimental services are not covered.
(h) Investigational services are not covered except when it is clearly documented that all of the following apply:
(1) Conventional therapy will not adequately treat the intended patient's condition;
(2) Conventional therapy will not prevent progressive disability or premature death;
(3) The provider of the proposed service has a record of safety and success with it equivalent or superior to that of other providers of the investigational service;
(4) The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives;
(5) The service is not being performed as a part of a research study protocol;
(6) There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.
All investigational services require prior authorization. Payment will not be authorized for investigational services that do not meet the above criteria, or for associated inpatient care when a beneficiary needs to be in the hospital primarily because she/he is receiving such nonapproved investigational services."
"Cal. Code Regs. Tit. 22, § 51056.1 - Experimental Services
(a) Experimental services means those drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans.
(b) Investigational services means those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but:
(1) Testing is not complete; and
(2) The efficacy and safety of such services in human subjects are not yet established; and
(3) The service is not in wide usage.
(c) The determination that a service is experimental or investigational is based on:
(1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
(2) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
(3) Reference to current medical literature."

**Wisconsin** (Source: BadgerCare Plus and Medicaid Pharmacy Handbook)
"Managed Care: Prior Authorization Topic #400 Prior Authorization Procedures
BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA guidelines that differ from fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service."
MOLINA REVIEWER NOTE: ForwardHealth medical necessity criteria take precedence over the criteria in this policy when available. ForwardHealth policies must be reviewed prior to applying the criteria in

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this policy.
ForwardHealth Prior Authorization: Services Requiring Prior Authorization

**APPENDIX 1: Clinical Trial Phases for Investigational New Drugs**

Clinical trial phases for Investigational New Drugs are defined by the FDA as follows:

- Phase 1 trials are concerned primarily with determining dosing, documenting how a drug is metabolized and excreted and identifying acute side effects. A small number of healthy volunteers (between 20 and 80) are evaluated in Phase 1 trials.
- Phase 2 trials involve approximately 100 to 300 participants who have the disease or condition that theproduct could treat. Researchers seek to gather further safety data and preliminary evidence of the drug's efficacy, and they develop and refine research methods for future trials. Drugs showing effectiveness with little risks identified will move to Phase 3.
- Phase 3 trials include a population of patients between 1,000 to 3,000 with a disease. This phase further tests the product's effectiveness, monitors side effects, and compares the product's effects to a standard treatment, when available.
- Phase IV trials are conducted after a product is already approved, and on the market, to identify potential long-term risks, benefits, and optimal use, or to test the product in different populations of people, such as children.

**APPENDIX 2: AHFS Levels of Evidence Rating System**

Level 1: High strength/ Quality

- Evidence consists of at least one randomized, double-blind trial without important limitations (i.e., large treatment effect); intent-to-treat analysis used, confidence intervals reported. If one more than one trial is available, these trials have consistent results; or
- A meta-analysis of such trials with consistent results (i.e., low heterogeneity); or
- Evidence consisting of a non-blinded or single-blinded trial that meets study objective endpoints may be considered as Level 1 evidence in some cancer-related cases (i.e., NCI-sponsored cooperative group study or a multi-center trial)

Level 2: Moderate Strength/Quality

- Evidence consists of at least one non-blinded or single-blinded, randomized clinical trial; or
- Evidence consists of at least one non-blinded or single-blinded, non-randomized clinical trial; or
- A meta-analysis of randomized, controlled clinical trials with heterogeneous results if reasons for heterogeneity in individual trials are adequately discussed; or
- Evidence consists of at least one randomized, controlled clinical trial, but with methodological limitations (e.g., large number of patients lost to follow-up and no intent to-treat analysis and/or important data not recorded); or
- Evidence is inconsistent (i.e., two or more randomized controlled trials with unexplained, widely varying estimates of treatment effects, even if results of individual trials would constitute a strong Level 1 evidence when considered alone); or
- Evidence consisting of a non-blinded, non-randomized trial (e.g., a phase II study) may be considered as Level 2 in some cancer-related cases (e.g., rare cancers or cancers with limited available treatment options)

Level 3: Low Strength/Quality

- Evidence consists of observational studies, case reports or case series; may also include randomized- clinical trials with multiple serious deficiencies or study limitations.

Level 4: Opinion/Experience

- Expert consensus panel reports or expert reviewer’s comments

AHFS Grades of Recommendation

A: Recommended; Accepted

The drug or biologic should be used, is recommended, is useful/effective/beneficial in most cases

B: Reasonable Choice (Accepted, with Possible Conditions) (e.g., option)

The drug or biologic is reasonable to use under certain conditions (e.g., in certain patient groups), can be useful/effective/beneficial or is probably recommended or indicated.

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C: Not Fully Established (Unclear risk/benefit, equivocal evidence, inadequate data and/or experience)
Usefulness and/or effectiveness is unknown, unclear, or uncertain or is not well established relative to the standard of care.
D: Not Recommended (Unaccepted)
The drug or biologic is considered inappropriate, obsolete, or unproven; is not recommended, is not indicated, or is not useful/effective/beneficial; or may be harmful.

Available at: https://www.ahfsdruginformation.com/levels-of-evidence-rating-system/

## BACKGROUND AND OTHER CONSIDERATIONS

**BACKGROUND:**

Off-Label (also referred to as unlabeled or non-FDA-approved) drug use refers to the prescription of licensed drugs for clinical indications or in a manner different from that approved by the FDA and thus not included in the official FDA-approved labeling for the agents. Off-label drug use takes many forms, and versions of it occur in countries outside of the United States as well. Use of drugs for a clinical indication, in a patient population, through a route of administration, or with a dose not specified in the FDA-approved labeling can all be considered off-label.

A. Requests for coverage of medications or devices that are non-FDA approved or "off-label" will be considered on a case-by-case basis.
B. Determinations of coverage for an off-label use of a drug may be considered under ANY of the following circumstances:

- A single case exception to current coverage policies, due to unique circumstances
- Until relevant coverage policies undergo full review, revision and approval by the Molina Clinical Policy Committee (MCPC) or Molina Healthcare National P&T Committee
- In the absence of a coverage policy currently addressing the drug or the requested use of the drug

C. The Emergency Use Authorization (EUA) is a statutory authority which allows the FDA to help strengthen the public health protections against chemical, biologic, radiological, or nuclear (CBRN) threats by facilitating the availability and use of medical countermeasures (MCMs – i.e., drugs, biologics, vaccines, diagnostic tests, etc.) during public health emergencies. The EUA allows for the unapproved use (i.e., off label use) of an approved medical product (drug, biologic, vaccine, or device) or the use of an investigational/unapproved product in order to diagnose, treat, or prevent serious or life-threatening diseases or conditions caused by CBRN threat agents when there are no adequate, approved, and available alternatives. Refer to the FDA's website for the current list of products that the FDA has authorized for emergency use in response to the COVID-19 public health emergency, including: FDA, EUA

- In Vitro Diagnostic Products
- High Complexity Molecular-Based Laboratory Developed Tests
- SARS-CoV-2 Antibody Tests
- Personal Protective Equipment and Related Medical Devices
- Ventilators and Other Medical Devices
- Drug Products

Medications and vaccines that have not received final FDA marketing approval for any indication are considered investigational. Orphan designation is not synonymous with FDA-approval and orphan drug status has no significance in the evaluation of off-label treatments. An orphan drug is one that is used for the treatment of a rare disease or condition that either occurs in fewer than 200,000 individuals in the US or is more prevalent but for which there is no reasonable expectation that the cost of developing and

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marketing the drug in the US for such disease or condition would be recovered from US sales. The orphan drug designation is independent from marketing approval status and may apply to medications that are either approved or unapproved for marketing. For the purposes of this policy, orphan drug status has no significance in the evaluation of off-label treatments.

**Evidence-Based Review**

The following are currently the authoritative compendia for CMS approved clinical decision support tools to determine medically accepted indication of off-label use:

1. American Hospital Formulary Service-Drug Information (AHFS-DI)
2. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
3. Truven Micromedex DrugDex Compendium (DrugDex) [Successor to USP-DI]
4. Elsevier Gold Standard's Clinical Pharmacology Compendium (Clinical Pharmacology)
5. Wolters Kluwer Lexi-Drugs (Lexi-Drugs

**Standard Drug Reference Compendia**

"Compendia (compendiums)" is defined by Medicare as "a comprehensive listing of FDA-approved drugs and biological or a comprehensive listing of a specific subset of drugs and biological in a specialty compendium, for example, a compendium of anti-cancer treatment." In this revised definition, a compendium:

1. Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases;
2. Is indexed by drug or biological; and
3. Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

The following resources/references are considered acceptable and utilized by Molina Healthcare to determine medical necessity criteria based on the best available clinical evidence to support safety and efficacy. The order of these resources as listed below represents the hierarchy of evidence.

A. Applicable Federal or State mandates and guidelines:
   1. National Coverage Determinations
   2. Local Coverage Determinations
B. Corporate policy documents addressing new or existing technology
   1. Approved clinical decision support tools to determine medically accepted indication of off-label use: American Hospital Formulary Service-Drug Information (AHFS-DI)
   2. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
   3. Truven Micromedex DrugDex Compendium (DrugDex) [Successor to USP-DI]
   4. Elsevier Gold Standard's Clinical Pharmacology Compendium (Clinical Pharmacology)
   5. Wolters Kluwer Lexi-Drugs (Lexi-Drugs)

**Evaluation of Off-label Requests**

Molina Medical Reviewers/Staff, in addition to utilizing the above references with the hierarchy of evidence listed in this 'Evidence Based Review' section to evaluate a request for an off-label use, also considers/weighs the following factors based on the clinical literature [submitted by requesting Prescriber]:

- Submitted peer-reviewed literature* by requesting Prescriber

  *Peer-Review Medical Literature: Off-label uses that are supported by clinical research peer-reviewed medical literature that may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.
- Availability of published reports of well-designed and well-conducted investigations published in peer-review journals
- Assessment of the quality and level of evidence reflected in published reports and systematic reviews

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- Opinions and evaluations by national medical associations, consensus panels, or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale
- Absence of potential clinically important concerns about the drug/biologic such as increased toxicity with no substantial therapeutic gain
- Positive therapeutic perspective as reflected by clinical evidence, expert opinion, best practices, and/or authoritative guidelines
- Evidence of improved risk-to-benefit ratios (including compliance) relative to existing therapeutic alternatives
- The importance and severity of the disease
- Availability of alternative therapies and their relative toxicities, the number of patients affected by the disease, other patient population considerations (e.g., age, gender, pharmacogenomics), and other factors (e.g., cost and economic considerations) also are important considerations.

**CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:**

Coverage will not be authorized for Off-Label usage unless prior authorization request meets all criteria defined in the above section. Off-label drugs are not covered when the following circumstances are applicable:

1. This policy shall not be construed to require coverage for any drug when ANY of the following applies:
   - The FDA has determined its use to be contraindicated; or
   - The benefit plan excludes drug coverage (e.g., agents for impotency or weight loss); or
   - The benefit plan includes drug benefit limitations based on a formulary and the off-label drug is not part of the formulary
2. Requested use, regardless of medical necessity, is specifically excluded from coverage in a member's plan benefit.
   - Member's benefits and benefit exclusions (excluded products or treatments are not covered under this policy, e.g., agents for impotency or weight loss); AND
   - State mandates and regulations will supersede this policy when applicable, such as those governing off-label use of prescription drugs
3. Pharmaceutical agents (and vaccines) that have not received final FDA marketing approval for any indication or has not been fully licensed or approved by the FDA are considered investigational and coverage will not be authorized
4. Use is identified as not indicated by CMS (in the case of Medicare members) or the FDA; or Use is specifically identified as not indicated in at least one of the major compendia; or Use is determined (based on peer-reviewed literature) that the drug is not safe and effective
5. Use of a product with only an orphan drug designation and without FDA marketing approval NOTE: An "orphan drug" is a product that treats a rare disease (e.g., affecting fewer than 200,000 Americans). Products have FDA orphan drug approval when they meet the orphan drug designation and marketing criteria established by the FDA. Reference: U.S. Food and Drug Administration (FDA). Developing Orphan Products: FDA and Rare Disease Day. Last updated 09/26/2009. Available at: http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm107293.htm.
6. Use of any drug when the FDA has determined that use to be contraindicated
7. Services related to non-covered services are not covered (e.g., administration services)
8. Pre-marketing notification (PMN) or a 510(k) application: A 510(K) is a premarket submission made to FDA to demonstrate that the device to be marketed is as safe and effective, that is, substantially equivalent, to a legally marketed device (section 513(i)(1)(A) FD&C Act) that is not subject to premarket approval.
9. Expanded Access Program (EAP) (also referred to as 'Managed Access Program (MAP), Early Access Program, or Compassionate Use Program (CUP'): A pathway for physicians and patients with an immediately life-threatening condition or serious disease or condition to gain access to pre-approval, investigational product* outside of the clinical trial setting.
   - *Investigational medical product (drug, biologic, or medical device) for treatment outside

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of clinical trials when no comparable or satisfactory alternative therapy options are available.

- *Investigational drugs, biologics or medical devices have not yet been approved or cleared by FDA and FDA has not found these products to be safe and effective for their specific use. Furthermore, the investigational medical product may, or may not, be effective in the treatment of the condition, and use of the product may cause unexpected serious side effects.
- There must be an unmet clinical need. The provision of a investigational treatments through expanded access is granted by the drug manufacturer (sponsor); a regulatory body or third- party provider cannot facilitate access without sponsor approval. Access to investigational treatments requires the FDA's review and authorization and the active involvement of health care providers.
- Molina Healthcare may authorize coverage of FDA-approved drug products associated with a clinical trial through the Plan's standard authorization process, as applicable (PA, quantity limits, etc.)
- The investigational drug, cost of the treatment(s) or procedure(s) the clinical trial is investigating, or procedure(s) required to collect data for the study will not be authorized.

**OTHER SPECIAL CONSIDERATIONS:**

Molina Healthcare clinical reviewers or staff submitting case reviews to an Independent Review Organization (IRO) [e.g., Advanced Medical Review (AMR)] shall review the reference materials provided for decision-making.

1. Independent review reference materials which do not meet the requirements shall be routed back to the independent review organization and the following should be requested:
    a. An explanation of the clinical rational and relevant, current evidence used to support the decision shall be requested to be reviewed by both the independent review quality check process and the oversight physician at the organization
    b. Independent review organization to provide an assessment of the quality of evidence utilized by the Peer Reviewer to perform the review
    c. Reviews deemed of insufficient quality shall be requested to be re-reviewed at the expense of the independent review organization

## CODING/BILLING INFORMATION

***CODING DISCLAIMER.*** *Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.*

| HCPCS CODE | DESCRIPTION |
|---|---|
| NA | |

**AVAILABLE DOSAGE FORMS**:

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## REFERENCES


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| SUMMARY OF REVIEW/REVISIONS | DATE |
|---|---|
| ANNUAL REVIEW COMPLETED- No coverage criteria changes with this annual review | Q4 2025 |
| REVISION- Notable revisions:<br>Coding/Billing Information Template Update<br>Required Medical Information<br>Background | Q4 2024 |
| REVISION- Notable revisions:<br>Continuation of Therapy | Q4 2023 |
| REVISION- Notable revisions:<br>Required Medical Information<br>Continuation of Therapy<br>Duration of Approval<br>Prescriber Requirements<br>Age Restrictions<br>Quantity<br>Appendix<br>Background<br>Contraindications/Exclusions/Discontinuation<br>References | Q4 2022 |
| Q2 2022 Established tracking in new format | Historical changes on file |

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