

**Mandatory Generic
Effective 01/01/2025**

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
Specialty Limitations	N/A		
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview

Unless otherwise specified, prior authorization is required for a brand name drug with an interchangeable generic available. Requests for such brand name products are reviewed against the criteria in this policy. Additionally, if the interchangeable generic has medication-specific prior authorization criteria or is nonformulary then requests must also be reviewed against the applicable criteria for the generic.

Coverage Guidelines

Authorization may be granted for brand name products when ONE of the following criteria has been met:

1. The member has tried the generic formulation of the requested drug for the current indication and experienced an inadequate response or an adverse reaction.
2. Healthcare provider is requesting medication due to a drug shortage (documentation of drug shortage is required)

Limitations

1. Approvals for drug shortages will be granted for 2 months.
2. All other approvals will be granted for the lifetime of plan.
3. If applicable, any medication specific prior authorization or nonformulary criteria must also be met.
4. Any quantity limits applicable to the generic formulation will also apply to the brand name.

References

N/A

Review History

04/06/16 – Reviewed

04/17/19 – Reviewed

09/22/2021 – Reviewed Sept P&T; no clinical changes.

02/08/2023 – Reviewed and Updated for Feb P&T; added drug shortage language and duration of approval.

Effective 5/1/2023

11/13/2024 – Reviewed and updated for November P&T. Clarified verbiage for meeting applicable medication specific criteria to indicate criteria should be prior authorization or nonformulary criteria. Effective 01/01/2025.