EXPERIMENTAL/INVESTIGATIONAL USES

Formulary Status: Formulary, PA or Non-formulary
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: 1 year

Diagnosis Considered for Coverage:

- Experimental or investigational use, as defined below
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction:

- Prescriber restriction: provider is a board-certified specialist in the area of requested therapy

Clinical Information Required for Review:

- Diagnosis
- Previous therapy
- Supporting documentation

Coverage Criteria:

Per Evidence of Coverage (EOC) document, SFHP does not cover experimental or investigational care, defined as care that:

- Is not seen as safe and effective by generally accepted medical standards to treat a condition, or
- Has not been approved by the government to treat a condition

I. Initiation of Therapy:

- Requests not meeting criteria below will be denied as an excluded benefit
- If ALL the following are met, a request for experimental or investigational use will be reviewed by the SFHP Medical Director
    - The requested therapy is for a life-threatening (likely to cause death unless the course of disease is interrupted) or seriously debilitating (causes major irreversible morbidity) condition
        - If requested therapy is not for a life-threatening or seriously debilitating condition, utilize “Off-Label Uses” criteria:
            a. No other formulary medication has a medically accepted use for the patient’s specific diagnosis as referenced in the medical compendia AND
            b. Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
            c. Requested use can be supported by at least two published peer reviewed clinical studies
    - The requested therapy is a therapy approved by the FDA
    - Documentation is provided meeting any of the following for each standard therapy for the diagnosis:
        - Trial and failure of standard therapy(ies)
        - Contraindication to standard therapy(ies)
        - Documentation that the requested therapy is likely to be more beneficial to the member than standard therapy(ies):
            a. as evidenced by two documents from medical and scientific evidence (including peer-reviewed medical literature, federal research institutes findings, medical compendia and/or guidelines) OR
            b. as certified in writing by provider, and the provider is an in-network physician
            c. If the request is denied following review by SFHP Medical Director due to not meeting criteria (a) and (b) above, SFHP’s decision will be sent for examination via the independent medical review process for investigational/experimental uses

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Refer to “Initiation of Therapy” section

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Patient is stable and continuing the medication

References:

EXPERIMENTAL/INVESTIGATIONAL USES
• California Health and Safety Code 1370.4, Accessed at https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1370.4.&lawCode=HSC.
Last review/revision date: 1/2025

MEDICATIONS FOR TERMINAL ILLNESS

Formulary Status: Formulary, PA or Non-formulary
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: 1 year

Diagnosis Considered for Coverage:

- Terminal illness, as defined below

Prescribing Restriction:

- Prescriber restriction: provider is a board-certified specialist in the area of requested therapy

Clinical Information Required for Review:

- Diagnosis
- Previous therapy
- Supporting documentation

Coverage Criteria:

California Health and Safety Code Section 1368.1 refers to terminal illness as an incurable or irreversible condition that has a high probability of causing death within one year or less.

I. Initiation of Therapy:

- If a request for treatment is for terminal illness as defined above, approve if medication and dose are appropriate based on nature and severity of the terminal illness, and is not considered likely to cause undue harm
  - Criteria above overrides drug-specific criteria and Non-Formulary Medications criteria, when requested for terminal illness
  - If request is for experimental/investigational use in terminal illness, Experimental/Investigational Uses criteria must also be met
- For requests that are denied due to not meeting corresponding criteria above, the following will be provided to the enrollee within five business days of the denial:
  - A statement setting forth the specific medical and scientific reasons for denying coverage
  - A description of alternative treatment, services or supplies covered by the plan, if any

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Refer to "Initiation of Therapy" section

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Patient is stable and continuing the medication

References:

- California Health and Safety Code 1368.1, Accessed at https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1368.1.&lawCode=HSC.

Last review/revision date: 10/2024

NON-FORMULARY MEDICATIONS

Formulary Status: Non-formulary or Formulary, PA Criteria Required (without specific criteria)
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: 1 year

Diagnosis Considered for Coverage:

- FDA approved indications
- Off-label uses^: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies.

^Including fertility preservation when a covered treatment may directly or indirectly cause iatrogenic infertility, specifically ovarian stimulation for cryopreservation, or ovarian protection when cryopreservation is not feasible

Prescribing Restriction:

- Quantity Limit* As requested not to exceed FDA approved or off-label dose

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Clinical Information Required for Review:

- Diagnosis
- Previous therapy
- Supporting documentation

Coverage Criteria:

I. Initiation of Therapy:

- Approve if:
  - Drug-specific PA criteria does not exist for the requested drug AND
  - Appropriate diagnosis/indication for requested non-formulary medication or meets off-label criteria below AND
    Off-label criteria^:
    - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
    - Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
    - Requested use can be supported by at least two published peer reviewed clinical studies

    ^Including fertility preservation when a covered treatment may directly or indirectly cause iatrogenic infertility, specifically ovarian stimulation for cryopreservation, or ovarian protection when cryopreservation is not feasible
  - Appropriate dose of medication based on age (i.e. pediatric and elderly populations) and indication AND
  - In the absence of evidence supporting use of requested medication compared to preferred agents, documented trial and failure or inability to use all (but no more than 3) available preferred medications indicated for the diagnosis OR
  - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia OR
  - All other formulary medications are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy OR
  - PA Criteria Exception:
    - The provider either verbally or in writing has submitted a medical or member-specific reason why prior authorization criteria all or in part is not applicable to the member

      Medical reasons may include but are not limited to: Criteria requirements are not applicable to the member based on the uniqueness of the member's condition or other physical characteristics of the member's condition.

      OR

      Member-specific reasons may include but are not limited to:Mental and/or physical characteristics of the member which may inhibit the provider from obtaining all necessary prior authorization criteria requirements.

NON-FORMULARY MEDICATIONS

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:
- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- Request is for generic or single source brand AND
- The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:
- Patient is stable and continuing the medication AND
- Continuation of therapy is medically necessary

Exclusions from the pharmacy benefit:
- Healthcare provider administered drugs (exception: long-acting injectable drugs for necessary treatment of a mental health condition or substance use disorder)
- Cosmetic treatments
- Erectile dysfunction treatments (exception: medically necessary treatment of a mental health condition or substance use disorder)
- Infertility treatments (exception: iatrogenic infertility)
- Over-the-counter medications (except those included on the formulary, see Evidence of Coverage/printable formulary preamble)

References:

- DMHC All Plan Letter 20-001 (OPL) Newly Enacted Statues Impacting Health Plans
- Practice Committee of the American Society for Reproductive Medicine. Fertility preservation in patients undergoing gonadotoxic therapy or gonadectomy: a committee opinion. Fertility and Sterility. 2019; 112(6): 1022-33.
- Oktay K, Harvey BE, Partridge AH, et al. Fertility preservation in patients with cancer: ASCO clinical practice guideline update. J Clin Oncol. 2018; 36: 1994-2001.

Last review/revision date: 1/2025

STEP THERAPY EXCEPTION

Formulary Status: Formulary, step therapy required (For drugs without specific criteria)
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: up to indefinite for chronic therapy

Diagnosis Considered for Coverage:

- FDA approved indications
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction:

- Quantity Limit*: As requested not to exceed FDA-approved or off-label dose

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Clinical Information required for Review

- Diagnosis
- Previous therapy
- Supporting documentation

Coverage Criteria:

I. Initiation of Therapy:

I. Approve if:

- Appropriate diagnosis/indication for requested medication or meets off-label criteria below AND
  Off-label criteria:
  - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
  - Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
  - Requested use can be supported by at least two published peer reviewed clinical studies
- Documentation is provided of <u>ONE</u> of the following:
  - Sufficient prior trial and failure of the required step therapy drug(s) (e.g., due to lack of efficacy, diminished effect, or adverse event) OR
  - Contraindication or inability to use required step therapy drug(s) OR
  - Member-specific reason why step therapy criteria all or in part is not applicable to the member.
    a. Member-specific reasons may include but are not limited to: Mental and/or physical characteristics of the member which may inhibit the provider from obtaining all necessary prior authorization criteria requirements.
  - Medical justification why required step therapy drug(s) would be ineffective or the requested drug would be superior for the member's condition OR
  - Medical justification why required step therapy drug(s) has the potential to cause physical or mental harm or deterioration of the member's condition OR
  - Medical justification why the required step therapy drug(s) is expected to do any of the following:
    a. Worsen a comorbid condition
    b. Decrease the capacity to maintain a reasonable functional ability in performing daily activities
    c. Pose a significant barrier to adherence to, or compliance with, the current drug regimen or plan of care

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- Request is for generic or single source brand AND
- The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria above

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Patient is stable and continuing the medication

STEP THERAPY EXCEPTION
References: N/A
Last review/revision date: 1/2025

QUANTITY LIMIT EXCEPTION

Formulary Status: Formulary, PA or Non-formulary
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: up to indefinite for chronic therapy. For requests secondary to temporary drug shortages, approve for up to shortage duration or 1-2 months until shortage resolves

Diagnosis Considered for Coverage:

- FDA-approved indications
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction: N/A

Clinical Information Required for Review:

- Diagnosis
- Previous therapy
- Supporting documentation

Coverage Criteria:

I. Initiation of Therapy:

- Approve if:
  - Appropriate diagnosis/indication for requested medication or meets off-label criteria below AND
    Off-label criteria:
    - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
    - Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
    - Requested use can be supported by at least two published peer reviewed clinical studies
  - Member has a documented treatment failure with the drug prescribed at the quantity limit or requires a dose within prescribing guidelines that exceeds the quantity limit AND
  - Medical justification why the plan's quantity limit will be inadequate based on the member's condition and treatment history AND
  - Dose requested is supported by Medical Compendia, two peer-reviewed trials, or current treatment guidelines

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- Request is for generic or single source brand AND
- The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Medical justification for continuation of therapy

References: N/A

Last review/revision date: 10/2024

SAFETY EDIT EXCEPTION

Formulary Status: Formulary, PA or Non-formulary
*For drugs without specific criteria
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: 1 year*
**One month approval for duplication of therapy when transitioning from one agent to another*

Diagnosis Considered for Coverage:

- Dosing or use in age populations outside of FDA-approved or accepted off-label indications

Prescribing Restriction: N/A

Clinical Information Required for Review:

- Diagnosis
- Previous therapy
- Concurrent therapy
- Dose and duration of therapy
- Supporting documentation

Coverage Criteria:

I. Initiation of Therapy:

- **For requests exceeding the FDA or compendia max dose, administration frequency or duration of therapy recommendations, approve if:**
  - Patient has documented treatment failure with the drug at the maximum tolerated dose or maximum dose (whichever is the lesser dose), administration frequency or duration of therapy AND
  - Medical justification why the maximum dose, administration frequency or duration of therapy needs to be exceeded based on the member's condition or treatment history AND
  - Dose requested is supported by the Medical Compendia, current treatment guidelines, or two peer-reviewed studies
- **For requests for a duplication of therapy**
  - **Transition from one agent to another (**one month only**), approve if:**
    - Provider has outlined a plan to transition member to a similar drug OR
    - Provider has provided a dose titration schedule
  - **Ongoing concurrent therapy with two similar agents, approve if:**
    - Medical justification why treatment with more than one drug in the same class is required based on the patient's condition and treatment history OR
    - Provider has submitted disease state specific standard of care guidelines supporting concurrent therapy
- **For requests exceeding an age restriction, approve if:**
  - Medical justification why the drug is needed outside age limit
  - Indication and dose requested are supported by the Medical Compendia, current treatment guidelines, or two peer-reviewed studies

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- Request is for generic or single source brand AND

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Medical justification for continuation of therapy

References: N/A

Last review/revision date: 4/2024

BRAND NAME MEDICATION

Formulary Status: all

Coverage Duration:

- Refer to drug-specific PA criteria OR
- Indefinite for chronic medications OR
- 1 year for non-chronic medications

Diagnosis Considered for Coverage:

- FDA approved indications
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction:

- Quantity Limit* See drug-specific PA criteria OR as requested not to exceed FDA approved or off-label dose

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Clinical Information Required for Review:

- Diagnosis
- Previous therapy
- Supporting documentation for failure of generic alternatives

Coverage Criteria:

*SFHP has a mandatory generic policy and requires generic substitution when an equivalent generic product is available (exception: preferred brand medications)

I. Initiation of Therapy:

- Approve if:
  - The requested medication is in one of the following classes: anti-epileptics, immunosuppressants; OR
  - Appropriate diagnosis/indication for requested non-formulary medication or meets off-label criteria below AND
    Off-label criteria:
    - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
    - Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
    - Requested use can be supported by at least two published peer reviewed clinical studies
  - Trial and failure of at least **two** generic versions of the requested medication by different manufacturers per claims history or documentation from the provider (i.e., dates tried, reason for trial and failure) OR
  - Inability to use at least **two** generic versions of the requested medication by different manufacturers (e.g., two generic versions are not available) AND
  - Documented trial and failure or inability to use up to **three** preferred medications (if available) used to treat the documented diagnosis provided there is no evidence supporting use of the requested non-preferred medication compared to preferred medications AND
  - Any drug/class-specific criteria applicable to the generic formulation are met

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria AND
- Clear information provided documenting why generic versions cannot be used

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria AND
- Clear information provided documenting why generic versions cannot be used

References: N/A

Last review/revision date: 1/2025

PRIOR AUTHORIZATION EXCEPTION

Formulary Status: Formulary, PA

* Requests for exception to the drug's prior authorization criteria requirements

Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: 1 year

Diagnosis Considered for Coverage:

- FDA approved indications
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction: N/A

Clinical Information Required for Review:

- Diagnosis
- Previous therapy
- Concurrent therapy
- Dose and duration of therapy
- Supporting documentation

Coverage Criteria:

I. Initiation of Therapy:

- The provider either verbally or in writing has submitted a medical or member-specific reason why prior authorization criteria all or in part is not applicable to the member
  - Medical reasons may include but are not limited to:
    - Criteria requirements are not applicable to the member based on the uniqueness of the member's condition or other physical characteristics of the member's condition.

  OR
  - Member-specific reasons may include but are not limited to:
    - Mental and/or physical characteristics of the member which may inhibit the provider from obtaining all necessary prior authorization criteria requirements.

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- Request is for generic or single source brand AND
- Documentation of medical or member-specific why prior authorization criteria all or in part is not applicable to the member (see details in section I above)

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Medical justification for continuation of therapy

References: N/A

Last review/revision date: 4/2024

ORAL AND INTRAVENOUS ONCOLYTICS

Formulary Status: Formulary, PA

Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: Indefinite

Diagnosis Considered for Coverage:

- FDA approved indications
- Off-Label indications^: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium (evidence rating 2b or greater), Wolters Kluwer Lexi-Drugs, Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

  ^Including fertility preservation when a covered treatment may directly or indirectly cause iatrogenic infertility, specifically ovarian stimulation for cryopreservation, or ovarian protection when cryopreservation is not feasible

Prescribing Restriction:

- Authorized quantity: 30 days' supply
- Prescriber restriction: Prescriber must be oncologist or hematologist

Clinical Information Required for Review:

- Diagnosis
- Dose
- Prescriber specialty

Coverage Criteria:

I. Initiation of Therapy:

- Requested indication must be supported by NCCN category 2b or greater evidence rating. If the request is for a lower level of evidence rating, then medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g., allergic reaction, contraindication) AND
- Documentation is provided of results of genetic testing where required per drug package insert AND
- Documentation is provided of results of all required laboratory values and patient specific information (e.g., weight, ALT/AST, creatinine kinase, etc.) when recommended/required per drug package insert AND
- Requested quantity does not exceed FDA approved or standard off-label dose AND
- For use of GnRH agonists for fertility preservation when a covered treatment may directly or indirectly cause iatrogenic infertility, specifically ovarian stimulation for cryopreservation, or ovarian protection when cryopreservation is not feasible, review for coverage using American Society of Clinical Oncology (ASCO) and American Society for Reproductive Medicine (ASRM) criteria

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- Request is for generic or single source brand AND
- The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria

References: N/A

Last review/revision date: 4/2024

SOLID ORAL SUBSTITUTION

Formulary Status: Formulary, age limit (≤12 or 16y), OR non-formulary
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration: 1 year

Diagnosis Considered for Coverage:

- FDA-approved indications
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction:

- Quantity Limit*: FDA approved or standard off-label dose

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Clinical Information Required for Review:

- Dose
- Diagnosis

Coverage Criteria:

I. Initiation of Therapy:

- Approve if:
  - Appropriate diagnosis/indication for requested non-formulary medication or meets off-label criteria below AND
    Off-label criteria:
    - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
    - Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
    - Requested use can be supported by at least two published peer reviewed clinical studies
  - Documentation of trial and failure, intolerance, contraindication, or inability (e.g., inability to swallow, etc.) to use **tablet or capsule** formulation

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- Request is for generic or single source brand AND
- The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria AND
- Continued inability to use **tablet or capsule** formulation of the same medication

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Continued inability to use **tablet or capsule** formulation of the same medication

References: N/A

Last review/revision date: 10/2024

NON-FORMULARY EXTENDED-RELEASE FORMULATION

Formulary Status: Non-formulary
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration:
1 year to indefinite depending on drug class (indefinite for chronic use medications, e.g., anticonvulsants)

Diagnosis Considered for Coverage:

- FDA approved indications
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction:

- Quantity Limit*: FDA approved or standard off-label dose

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Clinical Information Required for Review:

- Diagnosis
- Previous therapy
- Dose

Coverage Criteria:

I. Initiation of Therapy:

- Approve if:
  - Appropriate diagnosis/indication for requested non-formulary medication or meets off-label criteria below AND
    Off-label criteria:
    - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
    - Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
    - Requested use can be supported by at least two published peer reviewed clinical studies
  - Documentation of trial and failure, intolerance, contraindication, or inability (e.g., compliance difficulty, etc.) to use **formulary immediate release** formulation if available

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Prescriber attests that member has been on this medication continuously before joining SFHP AND
- Request is for generic or single source brand AND
- The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Patient is stable and continuing the medication

References: N/A

Last review/revision date: 10/2024

COMPOUNDED MEDICATIONS

Formulary Status: Non-Formulary/Prior Authorization required
Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration:
Initial: Not to exceed 3 months
Reauthorization: 6 months

Diagnosis Considered for Coverage:

- Diagnosis appropriate for medications contained in the compounded product

Prescriber Restriction:

- Quantity Limit* 30-day supply

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Clinical Information Required for Review:

- Diagnosis
- Current therapy
- Other medications that have been used for diagnosis
- Comorbidities

Coverage Criteria:

I. Initiation Criteria
The plan may authorize coverage of compounded prescription medications with an ingredient cost greater than or equal to $75 when ALL the following criteria are met:

- The indication, therapeutic amount, and route of administration of each of the active ingredients in the compound are FDA-approved or CMS-recognized compendia supported, AND
- All the active ingredients included in the compound are FDA-approved medications (bulk chemicals are not FDA approved), AND
- If there are existing clinical coverage criteria for any of the active ingredients, those criteria must also be met for these ingredients, AND
- And one (1) of the following:
  - There is a current supply shortage of the commercial product, OR
  - The member has a medical need for a dosage form or dosage strength that is not commercially available, OR
  - The member had a trial and intolerance to or contraindication to the commercially available product (e.g., allergen/preservative/dye-free, adverse effects to binders/fillers/other active ingredients), OR
  - The commercial product has been discontinued by the pharmaceutical manufacturer for reasons other than lack of safety or effectiveness

II. Continuation of Therapy for NEW Members (within the last 6 months), approve if:

- Continuation of therapy is clinically appropriate AND
- Prescriber attests that member has been on this medication continuously before joining SFHP

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Continuation of therapy is clinically appropriate

Note: All the active ingredients included in the compound need to be included on the request for authorization

References: N/A

Last review/revision date: 10/2024

BLOOD GLUCOSE TEST STRIPS

Standard/Specific Therapeutic Class: *Medical Supplies/Diabetic Supplies*

Formulary Status:

- Formulary:
  - Accu-Chek SmartView, Accu-Chek Aviva Plus, Accu-Chek Guide Test Strips
- Formulary, PA required:
  - FreeStyle Libre reader and sensor**
- Non-formulary: all other testing supplies

** All other continuous glucose monitoring devices should be requested via the medical benefit

Coverage Duration: Indefinite

Diagnosis Considered for Coverage:

- Diabetes mellitus type 1 or 2, gestational diabetes

Clinical Information Required for Review:

- Diagnosis
- Previous medications

Prescribing Restriction:

- Quantity Limit*:
  - Test strips: #4 strips per day
  - FreeStyle Libre:
    - 3 sensors per 30 days (10-day) or 2 sensors per 28 days (14-day)
    - 1 reader per year

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Coverage Criteria:

I. Initiation of Therapy:

- For **Accu-Chek SmartView, Accu-Chek Aviva Plus, or Accu-Chek Guide test strips over formulary quantity limit,** approve if:
  - Medical need for glucose monitoring more frequent than 4 times daily, or 8 times daily in the case of gestational diabetes (e.g., Frequent hospitalizations, incidents of hypoglycemia, DKA hospitalizations etc.)
- For **FreeStyle Libre** reader/sensor system, approve if:
  - Patient has type I or II diabetes and is on basal + bolus insulin therapy (multiple injections per day) AND
  - There is documentation of medical need for glucose monitoring more frequent than 4 times daily (e.g., frequent hospitalizations, hypoglycemia, DKA, etc.) OR
  - There is documented contraindication/inability to use finger stick testing (e.g., fear of needles)
- For **Contour test strips**, approve if:
  - Test strips will be used with insulin pump
- For **Freestyle Test Strips, Prodigy No Coding Test Strips, OneTouch Ultra Test Strips**, approve if:
  - Trial and failure or inability use formulary strips: Accu-Chek SmartView, Aviva Plus, or Guide

II. For **Continuation of Therapy**, approve

References: N/A

Last review/revision date: 4/2024

NON-FORMULARY BLOOD GLUCOSE METERS

Standard/Specific Therapeutic Class: *Medical Supplies/Diabetic Supplies*

Formulary Status:

- Formulary:
  - Accu-Chek Guide Retail Care Kit
- Non-formulary: all other blood glucose meters

Coverage Duration: Indefinite

Diagnosis Considered for Coverage:

- Diabetes mellitus type 1 or 2, gestational diabetes

Prescribing Restriction:

- Quantity Limit*: 1 unit per year (365 days)

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Clinical Information Required for Review:

- Diagnosis
- Previous therapy

Coverage Criteria:

I. Initiation of Therapy:

- Approve if there is documentation of trial and failure or inability to use a formulary blood glucose meter (e.g., Prodigy Voice Blood Glucose Meter is needed due to visual impairment)
- For FreeStyle Libre reader/sensor system, refer to ”Blood Glucose Test Strips” criteria
  - All other continuous glucose monitoring devices should be requested via the medical benefit

II. Continuation of Therapy for NEW Members (within the last 6 months), refer to “Initiation of Therapy” criteria

References: N/A

Last review/revision date: 4/2024

SHORT-ACTING OPIOIDS

Standard/Specific Therapeutic Class: *Narcotic Analgesics*
Formulary Status:

- Formulary:
  - codeine tablet
  - hydromorphone (Dilaudid®) tablet
  - morphine sulfate (MS-IR®) tablet
  - oxycodone (Roxicodone®) tablet
  - tramadol (Ultram®) 50mg tablet
  - hydrocodone-acetaminophen (Vicodin®) 2.5-325, 5-325, 7.5-325, 10-325mg tablet
  - oxycodone-acetaminophen (Percocet®) 2.5-325, 5-325, 7.5-325, 10-325mg tablet
  - acetaminophen with codeine (Tylenol-Codeine #3®) 300-30mg tablet
  - acetaminophen with codeine (Tylenol-Codeine #4®) 300-60mg tablet
  - acetaminophen with codeine (Capital with codeine®) 300-15mg tablet
  - tramadol-acetaminophen (Ultracet®) 37.5-325mg tablet
  - oxymorphone tablet
  - morphine sulfate 10, 20, 100mg/5mL solution
  - oxycodone 5mg/5mL solution
  - oxycodone 20mg/mL oral concentrate
  - acetaminophen with codeine 120-12mg/5mL oral solution
  - acetaminophen with codeine 120-12mg oral suspension

Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration:

- Initial days' supply > 7 days: one-time only
- Subsequent quantity above listed limit: for duration requested up to one year
- For regimens > 500 MME/day: for hospice/cancer pain, indefinite; for non-cancer pain, up to one year
- Non-formulary drug: for duration requested up to one year

Diagnosis Considered for Coverage:

- Acute pain, chronic pain
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction:

- Quantity Limit*
  - *Initial fill day supply limit for new starts (no previous opioid claim in the past 180 days): 7 days*
  - *Subsequent fill quantity limit: #120 units per 30 days for products listed below:*
    - codeine tablet
    - hydromorphone (Dilaudid®) tablet
    - morphine sulfate (MS-IR®) tablet
    - oxycodone (Roxicodone®) tablet
    - codeine phosphate-acetaminophen (Tylenol w/codeine®) tablet
    - hydrocodone-acetaminophen (Vicodin®) 2.5-325, 5-325, 7.5-325, 10-325mg tablet
    - oxycodone-acetaminophen (Percocet®) 2.5-325, 5-325, 7.5-325, 10-325mg tablet
    - acetaminophen with codeine (Tylenol-Codeine #3®) 300-30mg tablet
    - acetaminophen with codeine (Tylenol-Codeine #4®) 300-60mg tablet
    - acetaminophen with codeine (Capital with codeine®) 300-15mg tablet
    - tramadol-acetaminophen (Ultracet®) 37.5-325mg tablet
  - *Subsequent fill quantity limit: #240 units per 30 days for products listed below:*
    - tramadol (Ultram®) 50 mg tablet
  - *Subsequent fill quantity limit: #360 units per 30 days for products listed below:*
    - morphine sulfate 10, 20, 100mg/5mL oral solution

SHORT-ACTING OPIOIDS

- oxycodone 5mg/5mL oral solution
- oxycodone 20mg/mL oral concentrate
- acetaminophen with codeine 120-12mg/5mL oral solution
- acetaminophen with codeine 120-12mg oral suspension

**Requests for quantities above indicated Quantity Limits will be reviewed on a case-by-case basis*

Clinical Information Required for Review:

- Diagnosis, dose
- Previous therapy

Coverage Criteria:

I. Initiation of Therapy:

- If request is for management of pain due to terminal illness and medication and dose requested is appropriate based on nature and severity of the diagnosis and not likely to cause harm, approve
- For requests for short-acting opioid medication over the initial day supply limit of 7, approve if:
  - Medication is prescribed by a practitioner involved with care of the diagnosis provided AND
  - If quantity requested exceeds subsequent fill quantity limit, criteria for such a quantity are met (see A below)
  - If medication is non-formulary, criteria for that drug are met (see B below) AND
  - One of the following:
    - Member has history of opioid use within the last 180 days documented through IPNS or CURES, or documented by requesting physician if member was on opioids out of state OR
    - Indication of cancer pain OR
    - Indication of palliative care OR
    - Indication of acute pain from a chronic diagnosis (i.e., sickle cell disease) OR
    - Expected duration of treatment is greater than 7 days based on indication, with documentation of indication and expected duration
- (A) For requests for formulary medication over subsequent fill quantity limit, approve if:
  - Use is short-term (i.e., less than 6 months requested) for post-operative or acute injury pain OR
  - Indication of chronic cancer pain OR
  - There is failure with or inability to use long-acting opiates (e.g., morphine sulfate ER tablets) OR
  - Higher dose is needed as part of a protocol to taper to a lower dose or off long-acting opiates
- (B) For non-formulary medications, approve if:
  - For requests for non-formulary strength of oxycodone-APAP or hydrocodone-APAP, documentation of trial or failure or inability to use formulary oxycodone-APAP or formulary hydrocodone-APAP (e.g., total daily APAP dose exceeded, unable to split tablets, etc.) or inability to use oxycodone and APAP as separate ingredient products
  - For requests for other non-formulary medications, approve if:
    - Documented trial and failure, intolerance, contraindication, or inability to use all (but no more than 3) available preferred medications indicated for the diagnosis OR
    - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
    - If the request is for a liquid oral or rectal dosage form, documentation of trial and failure, intolerance, contraindication or inability (e.g., inability to swallow, etc.) to use tablet or capsule formulation
- For total opioid regimens above 500 morphine milligram equivalents per day, approve if:
  - If request is for non-formulary medication, criteria for (B) above are met AND
  - One of the following is met:
    - Regimen is prescribed by or under the supervision of a hospice/palliative care specialist OR
    - Regimen is for pain caused by active cancer OR
    - Regimen is for chronic non-cancer pain and **all** of the following are met:
      a. Member has been referred to a pain management specialist
      b. Non-pharmacologic treatments (e.g., acupuncture, physical therapy, chiropractic adjustment, etc.) have been discussed with the member and/or the member has tried and failed appropriate non-pharmacological alternatives for pain
      c. Member has had trial and failure, intolerance of, or contraindication to **at least two** non-opioid analgesics (e.g., acetaminophen, NSAIDs, select anticonvulsants and antidepressants

if indicated for neuropathy or fibromyalgia)

d. Documentation is provided that the prescribing provider has reviewed CURES database for the member, and the member is not receiving opioids from any other prescriber outside the requesting provider's practice
e. Documentation is provided that the prescriber reviewed the potential risks of ultra-high dose opioid use with the member
f. Documentation is provided that the prescriber has evaluated the member's treatment history for evidence of benefit with opioid titration in terms of function as well as pain score goals
g. Documentation is provided that the member has received a prescription for naloxone and education for use
h. Documentation is provided that urine drug screens are being utilized to assess for illicit drug use and/or compliance
i. The provider attests that the member has no known opioid overdose episodes in the last year (i.e., hospitalizations or use of naloxone)
j. If the member is currently on a benzodiazepine (filled in the last 6 months), documentation is provided of a plan to taper the benzodiazepine and that the prescriber reviewed risks of combination opioid-benzodiazepine use

- For off-label indications or dosing, approve if:
  - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
  - Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
  - Requested use can be supported by at least two published peer reviewed clinical studies

II. Continuation of Therapy for NEW Members (within the last 6 months), refer to "Initiation of Therapy" section

- Refer to "Initiation of Therapy" section but:
  - approve up to 2 months on non-preferred medication to allow transition to preferred agents
  - approve up to 6 months on opioid regimens >500 morphine milligram equivalents per day to allow evaluation for tapering protocol and/or non-opioid treatment

III. Continuation of Therapy for EXISTING Members (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if:

- Patient is stable and continuing the medication
- For dose increases from previous approval to quantity > #120 per 30 days, criteria for subsequent fill quantity limit (A) are met

References:

- CDC Clinical Practice Guideline for Prescribing Opioids for Chronic Pain — United States, 2022. Recommendations and Reports / November 4, 2022 / 71(3); 1–95. Accessed https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm
- State of California-- Health and Human Services Agency, Department of Health Care Services. All Plan Letter 19-012. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-012.pdf. revised 11/15/2019.

Last review/revision date: 4/2024

LONG-ACTING OPIOIDS

Therapeutic Class: *Analgesics: Opiates, Long-Acting*

Formulary Status:

- Formulary: morphine sulfate ER tablet (MS Contin®)
- PA required:
  - fentanyl transdermal (Duragesic®) 12, 25, 37.5, 50, 62.5, 75, 87.5, 100mcg/h patch
  - oxycodone ER (Oxycontin®) tablet
  - morphine sulfate (Kadian®) 10, 20, 30, 40, 50, 60, 80mg 24h ER capsule
- Non-formulary:
  - buprenorphine (Butrans®) transdermal patch
  - methadone
  - morphine sulfate (Avinza®) 45, 75, 90, 120mg 24h ER capsule
  - hydromorphone (Exalgo®) 24h ER abuse-deterrent tablet
  - oxymorphone 12h ER tablet
  - Oxycontin® (oxycodone) ER tablet
  - Xtampza® ER (oxycodone) 12h ER abuse-deterrent tablet
  - Nucynta® (tapentadol) 12h ER tablet

Multi-source brand drugs are NF; requests must also follow Brand Name Medication criteria in addition to this criteria

Coverage Duration:

- For non-preferred/non-formulary drugs: for duration requested up to one year
- For regimens > 500 MME/day: for hospice/cancer pain, indefinite; for non-cancer pain, up to one year

Diagnosis Considered for Coverage:

- Chronic pain
- Off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies

Prescribing Restriction:

- Quantity Limit*:
  - morphine sulfate ER tablets: #90 per 30 days
  - buprenorphine patch: #4 patches per 28 days
  - fentanyl patch: #15 patches per 30 days
  - oxycodone ER, oxymorphone ER, Nucynta® ER, Xtampza® ER: #60 per 30 days
  - methadone: #180 per 30 days (up to 60 mg/day)
  - morphine sulfate 24h caps, hydromorphone ER: #30 tablets per 30 days

**NOTE: doses above quantity limits are allowed for cancer pain*

Clinical Information Required for Review:

- Previous therapy
- Dose

Coverage Criteria:

I. Initiation of Therapy:

- If request is for management of pain due to terminal illness and medication and dose requested is appropriate based on nature and severity of the diagnosis and not likely to cause harm, approve
- For **fentanyl patch, morphine sulfate ER caps, oxycodone ER,** approve if:
  - there is documentation of trial and failure, intolerance, contraindication, or inability (i.e., drug interaction, allergy, adverse reaction, etc.) to use **morphine sulfate ER tablets at an adequate (equianalgesic) dose** OR
  - there is documentation of pain caused by active cancer
- For **methadone** or **buprenorphine patch**, approve if:
  - Diagnosis of pain
  - There is documentation of trial and failure, intolerance, contraindication, or inability (i.e., drug interaction,

allergy, adverse reaction, etc.) to use the following alternatives AND
    - short-acting opiates AND
    - morphine sulfate ER tablets AND one other long-acting opioid at an adequate (equianalgesic) dose
  - Naloxone has been prescribed for the member
- For requests for other non-formulary medications, approve if:
  - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia
  - There is documentation of trial and failure, intolerance, contraindication, or inability (i.e., drug interaction, allergy, adverse reaction, etc.) to use ALL of the following alternatives at an adequate (equianalgesic) dose
    - Morphine sulfate ER tablets or capsules AND
    - Fentanyl patches AND
    - Oxycodone ER
  - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia

- For total opioid regimens above 500 morphine milligram equivalents per day, approve if:
  - If request is for non-formulary medication, criteria above are met AND
  - One of the following is met:
    - Regimen is prescribed by or under the supervision of a hospice/palliative care specialist OR
    - Regimen is for pain caused by active cancer OR
    - Regimen is for chronic non-cancer pain and **all** of the following are met:
      a. Member has been referred to a pain management specialist
      b. Non-pharmacologic treatments (e.g., acupuncture, physical therapy, chiropractic adjustment, etc.) have been discussed with the member and/or the member has tried and failed appropriate non-pharmacological alternatives for pain
      c. Member has had trial and failure, intolerance of, or contraindication to **at least two** non-opioid analgesics (e.g., acetaminophen, NSAIDs, select anticonvulsants and antidepressants if indicated for neuropathy or fibromyalgia)
      d. Documentation is provided that the prescribing provider has reviewed CURES database for the member, and the member is not receiving opioids from any other prescriber outside the requesting provider's practice
      e. Documentation is provided that the prescriber reviewed the potential risks of ultra-high dose opioid use with the member
      f. Documentation is provided that the prescriber has evaluated the member's treatment history for evidence of benefit with opioid titration in terms of function as well as pain score goals
      g. Documentation is provided that the member has received a prescription for naloxone and education for use
      h. Documentation is provided that urine drug screens are being utilized to assess for illicit drug use and/or compliance
      i. The provider attests that the member has no known opioid overdose episodes in the last year (i.e., hospitalizations or use of naloxone)
      j. If the member is currently on a benzodiazepine (filled in the last 6 months), documentation is provided of a plan to taper the benzodiazepine and that the prescriber reviewed risks of combination opioid-benzodiazepine use
- For off-label indications or dosing, approve if:
  - No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND
  - Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR
  - Requested use can be supported by at least two published peer reviewed clinical studies

II. Continuation of Therapy for NEW Members (within the last 6 months):

- Refer to "Initiation of Therapy" section but:
  - approve up to 2 months on non-preferred medication to allow transition to preferred agents

LONG-ACTING OPIOIDS
○ approve up to 6 months on opioid regimens >500 morphine milligram equivalents per day to allow evaluation for tapering protocol and/or non-opioid treatment **III. Continuation of Therapy for EXISTING Members** (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if patient is stable and continuing the medication
References: • CDC Clinical Practice Guideline for Prescribing Opioids for Chronic Pain — United States, 2022. Recommendations and Reports / November 4, 2022 / 71(3); 1–95. Accessed https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm • State of California-- Health and Human Services Agency, Department of Health Care Services. All Plan Letter 19-012. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-012.pdf. Revised 11/15/2019.
Last review/revision date: 4/2024