New Hampshire Medicaid Fee-for-Service Program

New Drug Product Criteria

Approval Date: January 22, 2024

Medications

All FDA-approved medications shall be added to the NH Medicaid FFS program system as restricted coverage for their first six months on the market (as determined by the date of their addition to FDB file). Magellan Rx Management will code the system so that pharmacies will receive a denial at POS of "**NCPDP code 70; drug not covered**."

For drugs belonging to therapeutic drug classes that are subject to the Preferred Drug List (PDL), all drugs will be considered non-preferred until the class is again up for review.

The Medicaid Medical Director shall determine whether a newly approved drug will be covered unrestricted or require prior authorization criteria from the Drug Utilization Review (DUR) board.

For drugs that fall into categories that are subject to restrictions imposed by clinical prior authorizations (PA), a six-month PA will be imposed until clinical review has been undertaken by DUR. If review has not occurred by six months, the drug will be added to existing PA initiatives using the existing criteria for override.

For drugs that do not fall into any existing management tools, a six-month PA will be imposed until clinical review has been undertaken by DUR or the Medicaid medical director has determined that no restrictions shall be placed on the newly approved drug. However, if the review or an exemption has not occurred by six months, the drug will remain restricted until said review or exemption occurs.

New Hampshire Medicaid FFS program will cover no new drug until it has either been reviewed by the DUR or has received an exemption from any authorization from the state's Medicaid medical director.

Exemptions

If the Medicaid medical director determines that a new drug should be exempted from the six-month exclusion period, then the Medicaid medical director may make an exemption and allow for immediate coverage of the drug. Categorical exemption will be applied to antiretrovirals and chemotherapeutic drugs used to treat cancer.

Criteria for Approval

1. Allergy to all medications not requiring prior approval.
2. Contraindication to or drug-to-drug interaction with all medications not requiring prior approval.
3. History of unacceptable/toxic side effects to all medications not requiring prior approval.
4. Therapeutic failure of at least two medications within the same class not requiring prior approval.
5. An indication that is unique to a non-preferred agent and is strongly supported by peer-reviewed literature or an FDA-approved indication.

Length of Authorization: One year

References

- The Omnibus Reconciliation Act of 1993 (OBRA 1993) (P.L. 103-66) section 1927.
- http://www.cms.hhs.gov/medicaid/drugs/mrphistory.asp

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutics Committee	New prior authorization	03/18/2004
Commissioner	Approval	07/24/2004
DUR Committee	Revision	03/22/2010
Commissioner	Approval	04/30/2010
DUR Committee	Revision	03/20/2017
Commissioner	Approval	06/08/2017
DUR Committee	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Committee	Revision	10/28/2019
Commissioner Designee	Approval	12/03/2019
DUR Committee	Revision	12/15/2020
Commissioner Designee	Approval	02/24/2021
DUR Committee	Revision	06/02/2022
Commissioner Designee	Approval	07/12/2022
DUR Committee	Revision	12/08/2023
Commissioner Designee	Approval	01/22/2024