Washington State Health Care Authority

Brands with Generic Equivalents

Non-Clinical Policy No. 0001 Effective Date: 4/1/2019

Notes:

- For non-preferred agents in this class/category, patients must have had an inadequate response to at least TWO* preferred agents, have a documented intolerance due to severe adverse reaction or contraindication.
  *If there is only one preferred agent in the class/category documentation of inadequate response to ONE preferred agent is needed
- If a new-to-market drug falls into an existing class/category, the drug will be considered non-preferred and subject to this class/category prior authorization (PA) criteria

Background:

This is a general pharmacy program policy applicable to brand name products with a generic equivalent available.

Policy:

Criteria	
Initial Authorization	In addition to any drug class or drug specific policy criteria. All criteria must be met in order to approve. 1. Trial of two* preferred products, other than the generic equivalent to the requested brand; and 2. Trial of the generic equivalent of the product being requested from 5 manufacturers. If fewer than 5 manufacturers, must try all manufacturers. Documentation should include length of trial and outcome. Exceptions to this policy should be made for unique circumstances supported by clinical judgement and documentation. If no additional criteria, **Approve for 6 months.**
Reauthorization	In addition to any drug class or drug specific policy criteria. Documentation of positive clinical response to treatment. If no additional criteria, **Approve for 12 months.**

History

Date	Action and Summary of Changes
03/22/2019	New Policy