

Clinical Policy: Off-Label Use Policy

Reference Number: LA.PMN.53

Effective Date: 04.28.21

Last Review Date: ~~01.24.21~~06.26.23

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Please note: This policy is for medical benefit.

Description

Off-label drug use is the utilization of an FDA-approved drug for uses other than those listed in the FDA-approved labeling or in treatment regimens or populations that are not included in approved labeling.

FDA Approved Indication(s)

Varies by drug product.

Policy/Criteria

~~Prior authorization is required.~~ Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections that all medical necessity determinations for off-label uses be considered on a case-by-case basis by a physician, pharmacist or ad hoc committee, using the guidance provided within this policy.

I. Initial Approval Criteria

A. Requests for Off-Label Use (must meet all):

1. There are no pharmacy and therapeutic committee approved off-label use criteria for the diagnosis;
2. If a drug-specific clinical policy is available, the request is not for diagnoses or indications listed in Section III of the drug-specific clinical policy;
3. Use is supported by one of the following (a, b, or c):
 - a. The National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1, 2A, or 2B (see Appendix D);
 - b. Evidence from at least two high-quality, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i – iv):
 - i. Adequate representation of the member's clinical characteristics, age, and diagnosis;
 - ii. Adequate representation of the prescribed drug regimen;
 - iii. Clinically meaningful outcomes as a result of the drug therapy in question;
 - iv. Appropriate experimental design and method to address research questions (see Appendix F for additional information);
 - c. Micromedex DrugDex® with strength of recommendation Class I or IIa (see Appendix D);

4. Treatment is not for a benefit-excluded use (e.g., cosmetic);
5. Prescribed by or in consultation with an appropriate specialist for the diagnosis;
6. Failure of 2 alternative drugs that are FDA-approved for the requested indication and/or drugs that are considered the standard of care, tried at maximum indicated doses as described below (a, b, c, d, or e), unless contraindicated, clinically significant adverse effects are experienced, or request is for a product for treatment associated with cancer. For stage 4 advanced, metastatic cancer or associated conditions. Exception if “clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy.
 - a. The preferred biosimilar(s) of the requested brand name drug has been used, if available, unless member has contraindications to the excipients in all generics/biosimilars;
 - b. Both agents are generics (each from a different manufacturer) within the same therapeutic class as the requested agent;
 - c. If there is only 1 generic agent within the same therapeutic class as the prescribed agent, member must use at least one additional agent that is recognized as a standard of care for the treatment of the relevant diagnosis, provided that such agent exists;
 - d. If there are no generic agents within the same therapeutic class, member must use 2 alternatives that are recognized as standards of care for the treatment of the relevant diagnosis, provided that 2 such agents exist;
 - e. There are no generic agents within the same therapeutic class and no alternative agents recognized as standards of care for the treatment of the relevant diagnosis;
7. If request is for a non-preferred biologic product with an available biosimilar, one of the following (a or b):
 - a. Member must use the preferred biosimilar product(s), unless contraindicated or clinically significant adverse effects are experienced;
 - b. Request is for a product for treatment associated with cancer. For stage 4 advanced, metastatic cancer or associated conditions. Exception if “clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy.
8. Member has no contraindications to the prescribed agent per the product information label;
9. If applicable, prescriber has taken necessary measures to minimize any risk associated with a boxed warning in the product information label;
10. Dosing regimen and duration are within dosing guidelines recommended by clinical practice guidelines and/or medical literature.
- ~~1. There are no pharmacy and therapeutic committee approved off-label use criteria for the diagnosis;~~
- ~~2. Use is supported by one of the following (a, b, or c):~~
 - ~~a. The National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1, 2A, or 2B (see Appendix D);~~
 - ~~b. Evidence from at least two high-quality, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i—iv):~~

- ~~i. Adequate representation of the member's clinical characteristics, age, and diagnosis;~~
 - ~~ii. Adequate representation of the prescribed drug regimen;~~
 - ~~iii. Clinically meaningful outcomes as a result of the drug therapy in question;~~
 - ~~iv. Appropriate experimental design and method to address research questions (see Appendix E for additional information);~~
 - ~~e. Micromedex DrugDex[®] with strength of recommendation Class I or IIa (see Appendix D);~~
 - ~~3. Treatment is not for a benefit-excluded use (e.g., cosmetic);~~
 - ~~4. Prescribed by or in consultation with an appropriate specialist for the diagnosis;~~
 - ~~5. Failure of an adequate trial of at least two FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist, at maximum indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;~~
 - ~~6. Member has no contraindications to the prescribed agent per the product information label;~~
 - ~~7. If applicable, prescriber has taken necessary measures to minimize any risk associated with a boxed warning in the product information label;~~
 - ~~8. Dosing regimen and duration are within dosing guidelines recommended by clinical practice guidelines and/or medical literature.~~
- Approval duration: Duration of request or 6 months (whichever is less)

II. Continued Therapy

- 1. Member meets one of the following (a, b, or c):
 - a. Currently receiving medication via LHCC benefit;
 - b. Member has previously met initial approval criteria;
 - c. Use is supported by one of the following (i, ii, or iii):
 - i. The NCCN Drug Information and Biologics Compendium level of evidence 1, 2A, or 2B (see Appendix D);
 - ii. Evidence from at least two, high-quality, published studies in peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (1 – 4):
 - 1) Adequate representation of the member's clinical characteristics, age, and diagnosis;
 - 2) Adequate representation of the prescribed drug regimen;
 - 3) Clinically meaningful outcomes as a result of the drug therapy in question;
 - 4) Appropriate experimental design and method to address research questions (see Appendix F for additional information);
 - iii. Micromedex DrugDex with strength of recommendation Class I or IIa (see Appendix D);
- 2. Member is responding positively to therapy;
- 3. If request is for a non-preferred biologic product with an available biosimilar, one of the following (a or b):
 - a. Member must use the preferred biosimilar product(s), unless contraindicated or clinically significant adverse effects are experienced;

- b. Request is for a product for treatment associated with cancer. For stage 4 advanced, metastatic cancer or associated conditions. Exception if “clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy.
 - 1.4. If request is for a dose increase (quantity or frequency), member has been titrated up from the lower dose with documentation of partial improvement, and the new dose does not exceed dosing guidelines recommended by the product information label or clinical practice guidelines and/or medical literature.
 - ~~A. Requests for Off-Label Use (must meet all):~~**
 - ~~1. Member meets one of the following (a, b, or c):~~**
 - ~~a. Currently receiving medication via Louisiana Healthcare Connections benefit;~~**
 - ~~b. Member has previously met initial approval criteria;~~**
 - ~~c. Louisiana Healthcare Connections continuity of care programs apply to the requested drug and indication (e.g., seizures, heart failure, human immunodeficiency virus infection, and psychotic disorders [e.g., schizophrenia, bipolar disorder], oncology) with documentation that supports that member has received this medication for at least 30 days AND use is supported by one of the following (i, ii, or iii):~~**
 - ~~i. The NCCN Drug Information and Biologics Compendium level of evidence 1, 2A, or 2B (see Appendix D);~~**
 - ~~ii. Evidence from at least two, high-quality, published studies in peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (1—4):~~**
 - ~~1) Adequate representation of the member’s clinical characteristics, age, and diagnosis;~~**
 - ~~2) Adequate representation of the prescribed drug regimen;~~**
 - ~~3) Clinically meaningful outcomes as a result of the drug therapy in question;~~**
 - ~~4) Appropriate experimental design and method to address research questions (see Appendix E for additional information);~~**
 - ~~iii. Micromedex DrugDex with strength of recommendation Class I or IIa (see Appendix D);~~**
 - ~~2. Member is responding positively to therapy;~~**
 - ~~3. If request is for a dose increase (quantity or frequency), member has been titrated up from the lower dose with documentation of partial improvement, and the new dose does not exceed dosing guidelines recommended by the product information label or clinical practice guidelines and/or medical literature.~~**
- Approval duration: Duration of request or 12 months (whichever is less)**

II.III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Indications or diagnoses in which the drug has been shown to be unsafe or ineffective.**

II.IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

Varies by drug product

Appendix C: Contraindications/Boxed Warnings

Varies by drug product

Appendix D: General Information

- These criteria are to be used only when specific prior authorization criteria do not exist.
- The U.S. FDA approves drugs for specific indications included in the drug's product information label. The approval by the FDA means that the company can include the information in their package insert. Omission of uses for a specific age group or a specific disorder from the approved label means that the evidence required by law to allow their inclusion in the label has not been submitted to the FDA. Off-label, or "unlabeled," drug use is the utilization of an FDA-approved drug for indications, treatment regimens, or populations other than those listed in the FDA-approved labeling. Many off-label uses are effective and well-documented in the peer-reviewed literature, and they are widely used even though the manufacturer has not pursued the additional indications. Refer to the drug's FDA-approved indication(s) and labeling (varies among drug products).
- NCCN Categories of Evidence and Consensus:
 - Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
 - Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
 - Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
 - Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.
- Micromedex DrugDex Strength of Evidence, Strength of Recommendation, and Efficacy Definitions (Tables 1, 2, and 3):

Table 1. Strength of Recommendation		
Class I	Recommended	The given test or treatment has been proven to be useful, and should be performed or administered.
Class IIa	Recommended, In Most Cases	The given test, or treatment is generally considered to be useful, and is indicated in most cases
Class IIb	Recommended, In Some Cases	The given test, or treatment may be useful, and is indicated in some, but not most, cases.
Class III	Not Recommended	The given test, or treatment is not useful, and should be avoided.
Class Indeterminate	Evidence Inconclusive	Not applicable

Table 2. Strength of Evidence	
Category A	Category A evidence is based on data derived from: Meta-analyses of randomized controlled trials with homogeneity with regard to the directions and degrees of results between individual studies. Multiple, well-done randomized clinical trials involving large numbers of patients
Category B	Category B evidence is based on data derived from: Meta-analyses of randomized controlled trials with conflicting conclusions with regard to the directions and degrees of results between individual studies. Randomized controlled trials that involved small numbers of patients or had significant methodological flaws (e.g., bias, drop-out rate, flawed analysis, etc.). Nonrandomized studies (e.g., cohort studies, case-control studies, observational studies)
Category C	Category C evidence is based on data derived from: Expert opinion or consensus, case reports or case series
No Evidence	Not applicable

Table 3. Efficacy		
Class I	Effective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective
Class IIa	Evidence Favors Efficacy	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy.
Class IIb	Evidence is Inconclusive	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion argues against efficacy.
Class III	Ineffective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is ineffective.

Appendix E: Appropriate Experimental Design Methods

- Randomized, controlled trials are generally considered the gold standard; however:
 - In some clinical studies, it may be unnecessary or not feasible to use randomization, double-blind trials, placebos, or crossover.
 - Non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
- Case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

IV.V. Dosage and Administration

Varies by drug product

V.VI. Product Availability

Varies by drug product

VI.VII. References

1. Food and Drug Administration. Guidance for Industry: Distribution of Scientific and Medical Publications on Unapproved New Uses - Recommended Practices. February 2014. Available at: <https://www.fda.gov/media/88031/download>. Accessed August 1, 2022.
2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 2, 2022.
- ~~1. Food and Drug Administration. Good Reprint Practices for the Distribution of Medical Journal Articles and Medical or Scientific Reference Publications on Unapproved New Uses of Approved Drugs and Approved or Cleared Medical Devices. January 2009. Available at: <http://www.fda.gov/RegulatoryInformation/Guidances/ucm125126.htm>. Accessed August 3, 2020.~~
- ~~2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 3, 2020.~~

Reviews, Revisions, and Approvals	Date	<u>LDH Approval Date</u>
Converted corporate to local policy.	01.21	<u>04.28.21</u>
<u>Applied State-mandated redirection bypass for cancer for all redirection requests not just biologics;</u> <u>Added redirection to preferred biosimilar products for continued therapy.</u> <u>Added requirement if a drug-specific clinical policy is available, the request is not for diagnoses or indications listed in Section III of the drug-specific clinical policy; clarified drug failure requirements by consolidating multiple requirements and including various scenarios for biosimilars and generics, separated the following as an additional option for added clarity: “There are no generic agents within the same therapeutic class and no alternative agents recognized as standards of care for the treatment of the relevant diagnosis”</u> <u>Added clarification to initial authorization if request is for a non-preferred biologic with an available biosimilar, member must use the preferred biosimilar product(s).</u> <u>References reviewed and updated.</u> <u>Added blurb this policy is for medical benefit only.</u>	06.26.23	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

©2023 Louisiana Healthcare Connections. All rights reserved. All materials are exclusively owned by Louisiana Healthcare Connections and are protected by United States copyright law

CLINICAL POLICY
No Coverage Criteria/Off-Label Use



and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Louisiana Healthcare Connections. You may not alter or remove any trademark, copyright or other notice contained herein. Louisiana Healthcare Connections is a registered trademark exclusively owned by Louisiana Healthcare Connections.