Washington State Health Care Authority

Brands with Biosimilars or A-rated Generics

Non-Clinical Policy No. 0001-3 Effective Date: 7/1/2025

Note:

- *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.*

To see the list of the current Apple Health Preferred Drug List (AHPDL), please visit: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Background:

This is a general pharmacy program policy applicable to brand name products with an A-rated generic, biosimilar, or interchangeable biosimilar available.

Policy:

Criteria	
Initial Authorization	In addition to any drug class or drug specific policy criteria. All criteria must be met to approve. 1. Trial of two* preferred products, other than the A-rated generic, biosimilar, or interchangeable biosimilar to the requested brand; AND 2. Trial of an A-rated generic, biosimilar, or interchangeable biosimilar 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. All criteria must be met to approve. 1. Patient has previously met initial authorization criteria; AND 2. Documentation of positive clinical response to treatment. If no additional criteria, **Approve for 12 months.**

History

Approved Date	Effective Date	Version	Action and Summary of Changes
5.7.2025	7.1.2025	NC.0001-3	Update to reauthorization criteria to include: • Patient has previously met initial authorization criteria
2.3.2025	4.1.2025	NC.0001-2	Update to include: • A-rated generic, biosimilar or interchangeable biosimilar • Link to the Apple Health Preferred Drug List
3.22.2019	4.1.2019	NC.0001-1	New policy