



Original Effective Date: 05/01/2014

Current Effective Date: 12/28/2025

Last P&T Approval/Version: 10/29/2025

Next Review Due By: 10/2026

Policy Number: C15341-A

## Duplication of Therapy/High Risk Combination

### PRODUCTS AFFECTED

\*See Appendix for targeted therapeutic classes

### COVERAGE POLICY

*Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.*

#### **Documentation Requirements:**

*Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.*

#### **DIAGNOSIS:**

NA

#### **REQUIRED MEDICAL INFORMATION:**

This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

#### **A. THERAPEUTIC DUPLICATION:**

##### **1. (a) Documentation of the following:**

- i. Member has > 2 different drugs within the SAME targeted therapeutic class (See Appendix)  
AND

## Drug and Biologic Coverage Criteria

- ii. Documentation of prescriber review of medication list within the last 7 days and has provided evidence to support the combination to continue [DOCUMENTATION REQUIRED]  
AND
- iii. Documentation of anticipated length of concurrent therapy or proposed tapering schedule (if applicable)  
AND
- iv. IF CONCURRENT THERAPY REQUEST: Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

OR

(b) Documentation of the following:

- i. Member has  $\geq$  2 different drugs from targeted therapeutic classes that create a high risk for abuse, misuse, or CNS depression (See Appendix)  
AND
- ii. Documentation of prescriber review of medication list within the last 7 days and has provided evidence to support the combination to continue [DOCUMENTATION REQUIRED]  
AND
- iii. Documentation of anticipated length of concurrent therapy or proposed tapering schedule (if applicable)  
AND
- iv. IF CONCURRENT THERAPY REQUEST: Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

OR

(c) Prescriber attests that member is switching therapies and the therapeutic duplication of medications will not be used concurrently

## CONTINUATION OF THERAPY:

### A. THERAPEUTIC DUPLICATION:

- 1. Documentation of evidence to support the combination to continue [DOCUMENTATION REQUIRED]  
AND
- 2. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms  
AND
- 3. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity to the concurrent therapy

## DURATION OF APPROVAL:

Initial authorization: up to 6 months; for members switching therapies a 30-day override limit is appropriate.

Continuation of Therapy: up to 12 months or length of concurrent therapy need (whatever is shorter)

## PRESCRIBER REQUIREMENTS:

NA

## AGE RESTRICTIONS:

NA

## QUANTITY:

NA

## PLACE OF ADMINISTRATION:

NA

**DRUG INFORMATION****ROUTE OF ADMINISTRATION:**

NA

**DRUG CLASS:**

NA

**FDA-APPROVED USES:**

NA

**COMPENDIAL APPROVED OFF-LABELED USES:**

NA

**APPENDIX****APPENDIX:**

Molina Healthcare, Inc. targeted therapeutic classes for duplication of therapy review

MOLINA REVIEWER NOTE: The number of days of overlapping therapy that are allowed between duplicate products is dependent on the state and line of business.

TARGETED THERAPEUTIC CLASSES*		
Antidepressants	GERD	Opioids
Antihistamines	Gonadotropins	Phosphate binders
Antihyperlipidemics	Hematopoietic (CSFs)	Respiratory
Antihypertensives	Hormone replacement	Skeletal Muscle Relaxants
Antipsychotics	Immune globulins	Stimulants
Antiretrovirals	Immunomodulators	Urinary Antispasmodics
Benzodiazepines	Migraine	
Diabetes	NSAIDs	

\*Please note this list and program is reviewed and updated (if needed) on a quarterly basis.

Table reflects Q4 2025 program.

**BACKGROUND AND OTHER CONSIDERATIONS****BACKGROUND:**

A therapeutic class is a broad designation that groups medications together based on their intended therapeutic effect (e.g., analgesics, antibiotics, antidepressants, etc.). A therapeutic class is made up of medications within differing pharmacologic classes. The FDA defines a pharmacologic class as “a group of active moieties that share scientifically documented properties and is defined on the basis of any combination of three attributes of the active moiety: mechanism of action, physiologic effect, and chemical structure.” The Molina Healthcare therapeutic duplication program uses therapeutic classes for the basis of the program.

The Molina Healthcare therapeutic duplication program identifies targeted therapeutic duplication at point-of-sale based on overlapping fills of separate products. The therapeutic classes are chosen due to the potentially inappropriate clinical use and associated safety risks when using multiple products within the broader therapeutic class.

**CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:**

NA

## Drug and Biologic Coverage Criteria

### OTHER SPECIAL CONSIDERATIONS:

NA

### CODING/BILLING INFORMATION

**CODING DISCLAIMER.** Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.

HCPCS CODE	DESCRIPTION
NA	

### AVAILABLE DOSAGE FORMS:

NA

### REFERENCES

NA

SUMMARY OF REVIEW/REVISIONS	DATE
ANNUAL REVIEW COMPLETED- No coverage criteria changes with this annual review	Q4 2025
REVISION- Notable revisions: Required Medical Information Appendix Background	Q3 2025
REVISION- Notable revisions: Coding/Billing Information Template Update ANNUAL REVIEW COMPLETED- No coverage criteria changes with this annual review.	Q4 2024
REVISION- Notable revisions: Required Medical Information	Q4 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Duration of Approval Appendix	Q4 2022
Q2 2022 Established tracking in new format	Historical changes on file