



**Drug Name:** Prior Authorization Global Policy

**Date:** 7-2018

<b>Drug Name:</b>	<b>Prior Authorization Global Policy</b>
<b>Required Medical Information:</b>	<ul style="list-style-type: none"><li>• The medication is being used for an FDA approved indication and/or has compendia support.</li><li>• The provider has attached all relevant documentation (lab values, treatment plan, chart notes, etc.).</li><li>• The patient has tried all first line agents when applicable.</li></ul>
<b>Coverage duration:</b>	12 months