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| Effective Date: 7/2018 |
| Reviewed: 7/2018, 11/2019, 6/2020, 7/2020, 6/2021, 5/2022, 01/2023 |
| Scope: Medicaid |

Prior Authorization Global Criteria

POLICY

I. CRITERIA FOR APPROVAL

An authorization may be granted when all the following criteria are met:

- A. The requested drug/product is being used for an FDA-approved indication or a medically accepted indication as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or peer-reviewed published medical literature indicating that sufficient evidence exists to support use.
 - a. Is this medication being used for an oncology or hematology related indication?
- B. The prescribed dose and quantity fall within the FDA-approved labeling or within compendia-supported dosing guidelines.
- C. All relevant documentation (e.g. lab values, treatment plan, medical chart notes) is provided.
- D. The patient has experienced an inadequate treatment response or intolerance to all formulary first-line agents, including the generic and biosimilar alternative, if available.

II. CONTINUATION OF THERAPY

- A. Patient is tolerating treatment and is not experiencing any unacceptable toxicity from the drug.
- B. Patient has disease stabilization or improvement in disease (as defined by established clinical practice guidelines).

III. COVERAGE DURATION

- Up to 12 months as determined by FDA guidance and internal policies and procedures