Effective Date: 7/2018
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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

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

References

1. NHPRI Formulary Management Policy and Procedure.

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Neighborhood Health Plan OF RHODE ISLAND™