Prior Authorization Group Description	**Medications without specific criteria**
Drugs	Medications without specific criteria
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	Per package insert
Prescriber Restrictions	N/A
Coverage Duration	If the criteria is met, the request will be approved for up to a 12 month duration (depending on the diagnosis and usual treatment duration).
Other Criteria Revision/Review Date: 11/2024	**<u>Authorization:</u>** • Appropriate diagnosis/indication • Appropriate dose of medication based on age (i.e., pediatric and elderly populations) and indication. And patient meets one of the three following criteria: • Documented trial and failure or intolerance of two preferred medications used to treat the documented diagnosis. For medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated. • No other preferred has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia. • All other preferred medications are contraindicated based on the patients diagnosis, other medical condition, or medication therapy.