



Pharmacy Policy Title: Oncology Drugs

Recent review date: 7/2020

New review date: 7/2021

Field Name	Field Description
Prior Authorization Group	Oncology Drugs
Drugs	Oral and Injectable Oncology Medications (specialty or non-specialty) without medication specific criteria when requested for an oncology diagnosis
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) , and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber is an oncologist, or specialist in type of cancer being treated
Coverage Duration	If the criteria are met, the request will be approved for up to 6 month duration; if the criteria are not met, the request will be referred to a clinical reviewer for medical necessity review.
Other Criteria	<p>All of the following criteria must be met:</p> <ul style="list-style-type: none"> • The drug is requested through the medical benefit • The drug is being r Requested use must be a labeled for an indication or be that is supported by NCCN Category 1 or 2A level of evidence. If the request is for an off-label use supported by NCCN as Category 2B recommendation then medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g. allergic reaction, contraindication); if such a treatment regimen exists; AND • Documentation has been provided of the results of all required genetic testing where required per drug package insert; AND • Documentation has been provided of the results of all required laboratory values and patient specific information (e.g. weight, ALT/AST, Creatinine Kinase creatine kinase, etc.) necessary to ensure the patient has no contraindications to therapy per drug package insert; AND • The medication is being prescribed at a dose that is within FDA

<p>Revision/Review 5/2020 <u>7/2020</u></p>	<p>approved/NCCN guidelines.</p> <ul style="list-style-type: none">• <u>If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available</u><ul style="list-style-type: none">○ <u>The provider has either verbally or in writing submitted a member specific reason why the brand name biologic is required based on the member’s condition or treatment history.</u> <p>Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.</p>
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