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	**All of the following criteria must be met:** • The drug is requested through the medical benefit • Requested use must be a labeled indication or be 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); **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, 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 approved/NCCN guidelines. • If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available**, documentation of one of the following:** o The provider has ~~either~~ verbally or in writing submitted a member specific reason why the ~~brand name~~ **reference**

Revision/Review ~~11/2020~~ **10/2021**	biologic is required based on the member's condition or treatment history; o **The currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested** • If the request is for **abiraterone** ~~brand~~ **(**Zytiga**)** 500 mg tablet, a documented medical reason why two tablets of generic abiraterone acetate 250 mg cannot be used **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**