Field Name	Field Description
Prior Authorization Group Description	**Specialty Drugs**
Drugs	Oral and injectable specialty drugs without drug or class specific prior authorization criteria *** The Oncology Drugs prior authorization criteria will be applied to oncology drugs without drug or class 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	According to package insert
Prescriber Restrictions	N/A
Coverage Duration	If all of the conditions are met, requests will be approved for up to 6 months. If the conditions are not met, the request will be sent to a Medical Director/clinical reviewer for medical necessity review.
Other Criteria	**All of the following criteria must be met:** • The drug is requested through the medical benefit • The drug is requested for an appropriate use (per the references outlined in "Covered Uses" • The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses") • Documentation has been provided of a trial and failure of an appropriate alternative first line therapy, if one exists, for the requested use (per the references outlined in "Covered Uses"**)** or has a medical reason why these drug(s) cannot be used (e.g. intolerance, contraindication) • 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 reference 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**

Revision/Review Date ~~5~~**10/2021**	**Physician/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**