

Field Name	Field Description
Prior Authorization Group	Oncology Drugs/Therapies
Drugs	Oral and Injectable Oncology Medications and Oncology Gene Therapies (specialty or non-specialty) without product 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	<u>According to package insert or NCCN guidelines</u> N/A
Prescriber Restrictions	Prescribed by <u>by or in consultation with</u> 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>**Drug is being requested through the member’s medical benefit**</p> <p>All of the following criteria must be met:</p> <ul style="list-style-type: none"> • 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) • Documentation has been provided of the results of all required genetic testing where required per drug package insert • 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 • The medication is being prescribed at a dose <u>and duration</u> 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: <ul style="list-style-type: none"> ○ The provider has verbally or in writing submitted a member specific reason why the reference biologic is

<p>Revision/Review 711/20254</p>	<p>required based on the member’s condition or treatment history</p> <ul style="list-style-type: none">○ The currently available biosimilar product does not have the same appropriate use (per the references outlined in “Covered Uses”) as the reference biologic product being requested <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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