PRIOR AUTHORIZATION CRITERIA

REAUTHORIZATION STATE OF VIRGINIA

Status: CVS Caremark Criteria ***REG***
Type: Initial Prior Authorization ***Ref # 4685-A***

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- There is a previous prior authorization approval for the drug requested

AND

- The drug is prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders

AND

- The requested drug has been continuously issued for no fewer than three months

AND

- The drug was previously on formulary when the previous prior authorization was approved

AND

- The dosing does not exceed the FDA-labeled dosage

AND

- If the request is for a brand name product that has a generic equivalent on formulary, the patient had a trial and failure of the generic equivalent due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient

RATIONALE
The intent of the criteria is to provide coverage for prescription drugs in compliance with Code of Virginia S 1269, relating to health insurance; authorization of drug prescribed for the treatment of a mental disorder.

REFERENCES
1. §38.2-3407.15:2 of the Code of Virginia. S 1269. March 2021.

Written by: UM Development (JK)
Date Written: 06/2021
Revised:
Reviewed: Medical Affairs (CHART) 06/24/2021
External Review: 08/2021 (FYI)

CRITERIA FOR APPROVAL

1	Is there a previous prior authorization approval for the drug requested? [If no, then no further questions.]	Yes	No
2	Is the drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders? [If no, then no further questions.]	Yes	No
3	Has the requested drug been continuously issued for no fewer than three months? [If no, then no further questions.]	Yes	No

4	Was the drug previously on formulary when the previous prior authorization was approved? [If no, then no further questions.]	Yes	No
5	Does the dosing exceed the FDA-labeled dosage? [If yes, then no further questions.]	Yes	No
6	Is the request for a brand name product that has a generic equivalent on formulary? [If no, then no further questions.]	Yes	No
7	Has the patient had a trial and failure of the generic equivalent due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS – DO NOT USE FOR MEDICARE PART D**
1.	Go to 2	Deny	Use drug specific denial reason.
2.	Go to 3	Deny	Use drug specific denial reason.
3.	Go to 4	Deny	Use drug specific denial reason.
4.	Go to 5	Deny	Use drug specific denial reason
5.	Deny	Go to 6	Use drug specific denial reason
6.	Go to 7	Approve, 12 months	
7.	Approve, 12 months	Deny	Use drug specific denial reason.