PRIOR AUTHORIZATION CRITERIA

REAUTHORIZATION STATE OF VIRGINIA

Status: CVS Caremark Criteria

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? Yes No [If no, then no further questions.]

2 Is the drug prescribed for the treatment of a mental disorder listed in the most recent Yes No edition of the Diagnostic and Statistical Manual of Mental Disorders?

[If no, then no further questions.]

3 Has the requested drug been continuously issued for no fewer than three months? Yes No [If no, then no further questions.]

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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?		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.			

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