CVS/caremark

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **NUTRITIONAL SUPPLEMENTS-INBORN ERRORS OF METABOLISM**

BRAND NAME
(generic)

Status: Client Requested Criteria
Type: Initial Prior Authorization ***Ref # C9920-A***

CRITERIA FOR APPROVAL

1. Is the requested product being used for inborn error(s) of metabolism? Yes No

Mapping Instructions		
	Yes	**No**
1.	Approve, 12 Months	Deny

REFERENCES

1. Trustmark and Nippon Life Benefits Prior Authorization Approval Policy.

Written by: UM Development (SF)
Date Written: 12/2016
Revised:
Reviewed: Medical Affairs: (LMS) 12/2016

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

_____ _____
Signature Date

_____
Client Name