Prior Authorization Approval Criteria

Excess quantity requests (standard criteria)

Including, but not limited to, increased dose, frequency, and duration

Criteria for approval (bullet points below are all inclusive unless otherwise noted):

- The medication must be FDA approved for the medical condition being treated

  Or meet off-label use criteria by having evidence in compendia (e.g. AHFS, Micromedex, current accepted guidelines, etc.) that show the safety, efficacy, and improvement in net health outcomes concerning this therapy when compared to existing therapy for the medical condition being treated.

  Or accepted to be the standard treatment for the stated condition

- Must have a medical need for the increased quantity (including, but not limited to, increased dose, frequency, or duration).
- Must have tried the Fallon allowed quantity (dosing, frequency, and/or duration), yet requires a larger quantity (dosing, frequency, and/or duration).
- OR there is compendia/standards of care that recommend a larger quantity (dosing, frequency, and/or duration).

Exceptions:

Drug	Max QL or duration without override	Max QL or duration limit allowed with an override	Request > QL or duration	Denial reason
Aldara	48 units per year	Denied	Denied	Duration Not FDA approved
Erectile dysfunction drugs (Caverject, Cialis#, Edex, Levitra^, Muse, Staxyn^, Viagra^)	4 units per month (Muse=6 units per month)	Denied	Denied	Not a covered benefit
Erectile dysfunction drugs – MEDICAID* (Caverject, Cialis#, Edex, Levitra^, Muse, Staxyn^, Viagra^)	0	Denied	Denied	Not a covered benefit
Blood glucose monitor	1 per calendar year	Denied	Denied	Not a covered benefit
Inhaler spacers (i.e. Aerochamber)	1 per calendar year	Denied	Denied	Not a covered benefit
Peak flow meter	1 per calendar year	Denied	Denied	Not a covered benefit
OTC Nicotine replacement for MEDICAID	180 days per year	Denied	Denied	Not a covered benefit

Pre-natal vitamins (Oh Baby program)	90-day supply (up to 3 fills, only as part of Oh Baby program and only select NDCs)	Denied	Denied	Not a covered benefit

*ED drugs are not a covered benefit for any quantity for Medicaid. For BPH or Raynaud's, refer to Cialis criteria.
^ For Raynaud's, refer to Phosphodiesterase 5 inhibitors - post quantity limit criteria

Duration of Approval and Quantity:

Lovenox (enoxaparin), Bevyxxa (betrixaban) Arixtra (fondaparinux), Fragmin (dalteparin), Marinol (dronabinol), Zofran (ondansetron), Zuplenz (ondansetron): 6 months, quantity per provider request

All other medications: indefinite, quantity per provider request

Rev 09/12/07, 2/13/13
Reviewed: 12/13/17 – updated criteria for approval, duration of approval, and removed Enbrel, Lamisil, and plan B from the exceptions list.
Reviewed: 02/14/18- added Bevyxxa with a duration of 6 months. 10/10/18: added : OR there is compendia/standards of care that recommend a larger quantity (dosing, frequency, and/or duration).