Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	August 4, 2021

HEMADY® (dexamethasone tablets)

LENGTH OF AUTHORIZATION: Up to one year

INITIAL REVIEW CRITERIA:

- Patient must be ≥ 18 years of age.
- Patient must have a diagnosis of multiple myeloma.
- Hemady® must be prescribed in combination with other anti-myeloma products.
- Patient must not be experiencing a systemic fungal infection.
- Prescribed by, or in consultation, with a specialist, document specialty type.

CONTINUATION OF THERAPY:

- Patient met initial review criteria.
- Documentation of positive clinical response and the protocol regimen.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/
- Dosage Form: 20 mg tablets