

Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	November 16, 2012 May 16, 2017, June 4, 2020, June 27, 2023

MISCELLANEOUS DRUG CRITERIA

LENGTH OF AUTHORIZATION: UP TO ONE YEAR

INITIAL REVIEW CRITERIA:

- The patient has tried and failed medications on the Preferred Drug List or there is a reason (allergy, contraindication) that preferred drugs cannot be used; **AND**
- Documentation of previous trials such as progress notes, diagnostic evaluations and lab results are required; **AND**
- If the request is for a brand name drug and the generic is preferred, a trial of the generic drug or rationale why the generic cannot be used is required; **AND**
- The drug is requested for a medically accepted indication; **AND**
- Dosage and administration does not exceed FDA approved maximum for the patient’s indication.

CONTINUATION OF THERAPY:

- The patient met initial review requirements; **AND**
- Clinical response to therapy submitted (supporting documentation required); **AND**
- **Patient has not experienced any treatment-restricting adverse effects; AND**
- Dosage and administration does not exceed FDA approved maximum for the patient’s indication.

The list of preferred medications may be reviewed at the website below:

http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Please utilize the miscellaneous drug criteria if no specific criteria or form is listed for the drug or its class on the following link below:

http://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria.shtml