Table of Contents

Prior Authorization Guideline

GL-99538 Preferred Drugs- Arizona

Formulary Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Formulary Note

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Diagnosis	Prior Authorization Administrative Guideline for Preferred Drugs Without Drug-Specific Criteria
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

1.1.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology

AND

1.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

AND

1.3 If the patient is less than FDA minimum age, the prescriber attests they are aware of FDA labeling and feels the treatment with the requested product is medically necessary. (Document rationale for use)

Notes	Medications used solely for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
6/2/2021	Arizona Medicaid 7.1 Implementation