Priority Health
Commercial and Individual Plans

Prior Authorization Criteria

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Coming Soon

Priority Health™

This manual is updated frequently.

What is a prior authorization?

When a medication requires prior authorization, it means that certain criteria must be met before the medication can be covered. Prior authorization may also be required if a drug is being used in a manner that exceeds established coverage limits as stated on the Approved Drug List (ADL) or the Medical Drug List (MDL).

How to know when a medication requires prior authorization

The best way to know when a medication requires prior authorization is to use the Approved Drug List (ADL) or the Medical Drug List (MDL) tools. The ADL lists the medications covered under your pharmacy benefit and the MBDL lists the medications covered under your medical benefit (medications administered by a healthcare professional).

How to use this criteria document

Coverage of drugs depends on your prescription drug plan. Not all drugs included in this document are necessarily covered by your plan. This criteria document is meant to be used alongside the Approved Drug List (ADL) and the Medical Drug List (MDL) for your plan's drug coverage, with the following prior authorization forms:

- Pharmacy Prior Authorization form (general form used to request coverage for medications dispensed at the retail pharmacy requiring prior authorization)
- Medical Prior Authorization form (general form used to request coverage for medications administered by a healthcare provider under your medical benefit requiring prior authorization)
- Immune Globulin Request form (general form used to request coverage for intravenous or subcutaneous immune globulin)
- Oncology Pharmacy Drug Request form and Oncology Medical Drug Request form (general forms used to request coverage for chemotherapeutic medications requiring prior authorization under the pharmacy or medical benefit)

These forms may also be used when requesting coverage for medications that may not be listed under the ADL or MBDL (e.g., formulary exception requests), or for quantities that exceed the limits stated on either the ADL or MBDL (e.g., quantity limit exception requests) or other posted limitations in coverage (e.g., age limits per FDA-approved labeling).

Most drugs on this criteria document are listed in alphabetical order according to their trade name unless the drug is available generically in which the drug will be listed by its generic name. Occasionally, when two or more medications used to treat the same condition have the same coverage criteria, these may be grouped into one listing. One example would be the Antimigraine Agents, Preventive Treatment [Aimovig (erenumab), Emgality (galcanezumab), Ajovy (fremanezumab), Qulipta (atogepant), Vyepti (eptinezumab)].

Please note that authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. In situations such as this, please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication. For medications with step therapy requirements, please note that a documented trial and therapeutic failure or an intolerance or contraindication to the preferred medication is required.

Following initial authorization, coverage may be discontinued if the patient is noncompliant with pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy OR if patient no longer meets the initial criteria.