RxAdvance
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Clinical Policy Title:	Medical Necessity
Policy Number:	RxA.914
Drug(s) Applied:	All excluded drug(s)
Original Policy Date:	11/10/2025
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. **Initial Approval Criteria**

A. **Indication** (must meet all):

1. The patient cannot be switched to a formulary drug;
2. The requested drug is being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: NCCN, AHFS, Micromedex, current accepted guidelines)
3. The prescribed dose and quantity fall within the FDA-approved labelling or within dosing guidelines found in the compendia of current literature;
4. The patient has tried and had an inadequate treatment response or intolerance to ALL formulary alternatives unless the patient has a contraindication to ALL formulary alternatives. Documentation is required for approval.

Approval duration

All Lines of Business (except Medicare): 12 months

II. **Continued Therapy Approval**

A. **Indication** (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria.

Approval duration

All Lines of Business (except Medicare): 12 months

References

Not applicable

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	11/10/2025	12/11/2025

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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