# Manual Review Criteria

Reference Number: ARTC.PHAR.501
Last Review Date: 07/22 Revision Log

**Description**
This policy provides criteria to use for reviewing requests designated as manual review on the state website when there are no drug-specific criteria provided. Additionally, these criteria may be used to determine medical necessity for drugs requiring prior authorization (PA) when drug-specific criteria is not available.

**Policy**

**I.** Initial Approval Criteria

1. Requested indication is consistent with FDA-labeling, approved compendia, and/or current clinical practice guidelines. Indication has been confirmed by laboratory testing, if laboratory testing exists as the standard for diagnosis AND
2. Member has a medical reason supported by documentation for not using PDL alternatives or alternatives that would be appropriate based on current clinical practice/guidelines that do not require a PA with Arkansas Medicaid (see state memos), when such agents exist AND
3. Medication meets Claim Edits for age/gender/dose/quantity/cumulative quantity OR
   *For non-topicals*: if requesting outside of the claim edits, the requested medication meets FDA-labeling, compendium support, or has been studied and found to be safe and effective for the exception to the claim edit being requested OR
   *For topicals:* if requesting outside of the quantity edits, the quantity must be consistent with what is needed per BSA calculations for the area being treated.
4. If request is for combination product or alternative dosage form or strength of existing drugs, medical justification supports inability to use the individual drug products concurrently or alternative dosage forms or strengths (e.g., contraindications to the excipients of all alternative products) AND
5. Treatment is not for a benefit-excluded use (see Exclusions on Work Instructions) AND
6. Member has no contraindications to the prescribed agent per the product information label

Approval duration: Duration of request or 6 months (whichever is less)

**II.** Continued Therapy

1. Currently receiving medication via Centene benefit or Arkansas Medicaid benefit AND
2. Member has previously met initial approval criteria for diagnosis and clinical edits being requested AND
3. Member is responding positively to therapy.

Approval duration: Duration of request or 12 months (whichever is less)

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Policy developed | 03/20 | 07/20 |
| Annual review, no changes | | 07/21 |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Annual Review; updated policy description | 7/22 | 07/25/22 |