Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	 April 5, 2012

5-ASA DERIVATIVES, ORAL PREPARATIONS

LENGTH OF AUTHORIZATION: UP TO ONE YEAR

CRITERIA FOR APPROVAL:

1. Is there any reason that the patient cannot be switched to a preferred medication? Document details. Acceptable reasons include:
   - Allergy to the preferred medications in this class
   - Contraindication or drug to drug interaction with all preferred medications
   - History of unacceptable side effects
   - Indication involves the upper GI tract (in such cases Pentasa may be approved)

2. The requested medication may be approved if **both** of the following are true:
   - If there has been a therapeutic failure to no less than a two-month trial each, of at least 2 medications within the same class not requiring prior approval **AND**
   - The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

APPROVED INDICATIONS:

- Ulcerative Colitis
- Crohn's disease
- Ulcerative Proctitis