Commercial/Healthcare Exchange PA Criteria

Effective: September 17, 2020

Prior Authorization: Hemady

Products Affected: Hemady (dexamethasone) oral tablet

Medication Description: Dexamethasone is a long acting corticosteroid with minimal sodium-retaining potential. It decreases inflammation by suppression of neutrophil migration, decreased production of inflammatory mediators, and reversal of increased capillary permeability; suppresses normal immune response.

Covered Uses: Indicated in combination with other anti-myeloma products for the treatment of adults with multiple myeloma (MM)

Exclusion Criteria:

1. Known hypersensitivity to dexamethasone
2. Systemic fungal infections

Required Medical Information:

1. Diagnosis
2. Previous therapies tried and failed

Age Restrictions: 18 years of age and older

Prescriber Restrictions: Prescribed by, or in consultation with, an oncologist.

Coverage Duration: 12 months

Other Criteria:

A. Patient has a diagnosis of multiple myeloma; **AND**
B. Patient is using Hemady in combination with other anti-myeloma products; **AND**
C. Patient has had a trial and failure, intolerance, or contraindication to generic single dexamethasone oral tablets.

References:

1. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: December 5, 2019.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	9/17/2020