

## Priority Health Medicare Prior Authorization Criteria (Part D)

### Cometriq®

#### Products affected

- Cometriq®

#### Details

|                                     |  |
|-------------------------------------|--|
| <b>Covered uses</b>                 | All medically accepted indications not otherwise excluded from Part D. |
| <b>Exclusion criteria</b>           | N/A  |
| <b>Required medical information</b> | N/A  |
| <b>Age restrictions</b>             | N/A  |
| <b>Prescriber restrictions</b>      | N/A  |
| <b>Coverage duration</b>            | One year   |
| <b>Other criteria</b>               | N/A  |