



Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	April 20, 2012, November 16, 2015

**Elmiron® (pentosan)**

**LENGTH OF AUTHORIZATION: UP TO SIX MONTHS**

**Review Criteria:**

Must provide diagnosis for **interstitial cystitis (IC)**, confirmed by diagnosis code(s) **OR** by supporting clinical documentation.

**Maximum Dosage Limits:**

- *Adults:* 300 mg/day PO.
- *Elderly:* 300 mg/day PO.
- *Children and Adolescents:* Safe and effective use has not been established.