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Prior Authorization Guideline

Guideline Name	Leucovorin calcium

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name: Lederle Leucovorin, Leucovorin Calcium	
Approval Length	Approve for lifetime (12/31/2039)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Request is for an oncology or hematology related condition (e.g., part of a chemotherapy regimen, graft-versus host-disease or anemia)

OR

1.2 Both of the following:

1.2.1 Request is for cerebral folate deficiency with folate receptor autoantibodies

AND

1.2.2 One of the following:

1.2.2.1 Submission of medical records (e.g., chart notes) confirming diagnosis of both of the following:

1.2.2.1.1 Cerebral folate deficiency (CFD) - (CFD diagnosis typically requires spinal fluid testing that shows 5-methyltetrahydrofolate levels are low in the cerebrospinal fluid while peripheral folate status is normal)

AND

1.2.2.1.2 Folate receptor autoantibodies (FRAAs) - (Folate receptor autoantibody testing typically requires FRAT testing)

OR

1.2.2.2 The request is from a specialist (such as pediatric neurologist or metabolic specialist), clinical records provided document high clinical suspicion for CFD

OR

1.2.3 The request is for cerebral folate transport deficiency (CFTD) with a confirmed variant in the folate receptor 1 (FOLR1) gene (FOLR1-CFTD)

OR

1.3 The member is currently taking methotrexate