

ISSUE DATE January 30, 2017	EFFECTIVE DATE January 31, 2017	NUMBER *See below
SUBJECT Prior Authorization of Bronchodilators, Beta Agonists – Pharmacy Services		BY  Leesa M. Allen, Deputy Secretary Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate their MA enrollment every 5 years. Providers should log into PROMISE to check their revalidation date and submit a revalidation application at least 60 days prior. Enrollment (revalidation) applications may be found at http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the type of information needed to evaluate requests for prior authorization of prescriptions for Bronchodilators, Beta Agonists for medical necessity.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance Program and providing services in the fee-for-service delivery system, including pharmacy services to residents of long term care facilities.

BACKGROUND:

The Department of Human Services' (DHS) Pharmacy and Therapeutics (P&T) Committee meets semi-annually to review published peer-reviewed clinical literature and make recommendations relating to new drugs in therapeutic classes already included in the Preferred Drug List (PDL), changes in the status of drugs on the PDL from preferred to non-preferred and non-preferred to preferred, new quantity limits, and classes of drugs to be added

*01-17-10	09-17-09	27-17-08	33-17-09
02-17-08	11-17-08	30-17-09	
03-17-08	14-17-08	31-17-10	
08-17-09	24-17-08	32-17-08	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs Web site at
<http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm>

to or deleted from the PDL. The P&T Committee also recommends new guidelines or modifications to existing guidelines to evaluate requests for prior authorization of prescriptions for medical necessity.

DISCUSSION:

DHS is changing the designation of Striverdi Respimat from non-preferred to preferred. Striverdi Respimat is a long acting inhaled beta agonist. DHS is revising the guidelines to determine medical necessity of long acting inhaled beta agonists, based on the preferred designation of Striverdi Respimat.

PROCEDURE:

The procedures for prescribers to request prior authorization of Bronchodilators, Beta Agonists are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. DHS will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Bronchodilators, Beta Agonists) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

SECTION II
Bronchodilators, Beta Agonists

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Bronchodilators, Beta Agonists

A. Prescriptions That Require Prior Authorization

Prescriptions for Beta Agonist Bronchodilators that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Beta Agonist Bronchodilator. See Preferred Drug List (PDL) for the list of preferred Beta Agonist Bronchodilators at:
<https://papdl.com/preferred-drug-list>
2. A prescription for a preferred or non-preferred Long-Acting Beta Agonist Bronchodilator with a formulation that does not include a steroid
3. A prescription for a preferred or non-preferred, Long Acting or Short Acting Beta Agonist Bronchodilator when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs in PROMISe, the Department's Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication)

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Beta Agonist Bronchodilator, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For a non-preferred inhaled Beta Agonist Bronchodilator, whether the recipient has a history of therapeutic failure or intolerance of the preferred inhaled Beta Agonist Bronchodilators with a corresponding formulation including:
 - a. Short acting agents
 - b. Long acting agents

OR

2. For a non-preferred oral agent Beta Agonist Bronchodilator, whether the recipient has a history of therapeutic failure, contraindication, or intolerance of the preferred inhaled Beta Agonist Bronchodilators.

AND

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3. For either a preferred or non-preferred Long-Acting Beta Agonist Bronchodilator with a formulation that does not include a steroid, whether the recipient:

a. Does not have a diagnosis of asthma

OR

b. Has a diagnosis of asthma and has a concomitant prescription for a steroid

AND

4. For therapeutic duplication, whether:

a. The recipient is being titrated to, or tapered from, a drug in the same class

OR

b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested

OR

5. For all non-preferred Beta Agonist Bronchodilators and all Beta Agonist Bronchodilators with a formulation that does not include a steroid, whether the recipient does not meet the clinical review guidelines listed above, but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

C. Automated Prior Authorization Approvals

Prior authorization of a prescription for a non-preferred Beta Agonist Bronchodilator will be automatically approved when the PROMISe Point-of-Sale On-Line Claims Adjudication System verifies a record of paid claim(s) within 60 days prior to the date of service that documents that the guidelines to determine medical necessity listed in Section B. have been met

D. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the

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medical necessity of the request for a prescription for a non-preferred Beta Agonist Bronchodilator and a prescription for a Long-Acting Beta Agonist Bronchodilator with a formulation that does not include a steroid. If the applicable guideline in Section B is met, the reviewer will prior authorize the prescription. If the applicable guideline is not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.