



<b>ISSUE DATE</b> August 8, 2017	<b>EFFECTIVE DATE</b> August 8, 2017	<b>NUMBER</b> *See Below
<b>SUBJECT</b>  Prior Authorization of Intra-Articular Hyaluronates - Pharmacy Services		<b>BY</b>   Leesa M. Allen, Deputy Secretary Office of Medical Assistance Programs

**IMPORTANT REMINDER:** All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISE to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at:  
[http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S\\_001994](http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994).

**PURPOSE:**

The purpose of this bulletin is to:

1. Inform providers that the Department is adding the Intra-Articular Hyaluronates class of drugs to the Preferred Drug List (PDL)
2. Issue handbook pages that include the type of information needed to evaluate requests for prior authorization of prescriptions for Intra-Articular Hyaluronates 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.

*01-17-33	09-17-31	27-17-29	
02-17-28	11-17-28	30-17-29	
03-17-28	14-17-28	31-17-33	
08-17-34	24-17-29	32-17-28	33-17-32

**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>

**BACKGROUND:**

The Department of Human Services (Department) 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 PDL, changes in the status of drugs on the PDL from preferred to non-preferred and non-preferred to preferred, new quantity limits, and new classes of drugs to be added to or deleted from the PDL.

**DISCUSSION:**

During the May 17, 2017 meeting, the P&T Committee recommended that the Department add the Intra-Articular Hyaluronates (formerly Intra-Articular Hyaluronic Acid Agents) class of drugs to the PDL. The Department already requires a clinical prior authorization of all Intra-Articular Hyaluronic Acid Agents. The only change, other than the title of the class, is the addition of the standard guideline for non-preferred drugs - a documented history of therapeutic failure, contraindication or intolerance of the preferred Intra-Articular Hyaluronates. The P&T Committee recommendations were subject to public review and comment, and subsequently approved for implementation by the department.

**PROCEDURE:**

The procedures for prescribers to request prior authorization of Intra-Articular Hyaluronates are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapters related to Intra-Articular Hyaluronates) 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

Intra-Articular Hyaluronates

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**1. Requirements for Prior Authorization of Intra-Articular Hyaluronates (formerly Intra-Articular Hyaluronic Acid Agents)**

A. Prescriptions That Require Prior Authorization

Prescriptions for Intra-Articular Hyaluronates that meet the following condition must be prior authorized:

1. A prescription for a preferred or non-preferred Intra-Articular Hyaluronate. See the Preferred Drug List (PDL) for the list of preferred and non-preferred Intra-Articular Hyaluronates at: <https://papdl.com/preferred-drug-list>.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Intra-Articular Hyaluronate, the determination of whether the requested prescription is medically necessary will take into account whether:

1. The recipient has a diagnosis of osteoarthritis of the knee

**AND**

2. The recipient has a documented history of therapeutic failure, contraindication or intolerance to all of the following:
  - a. Non-pharmacologic treatments
  - b. Acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)
  - c. Intra-articular glucocorticoid injection

**AND**

3. The recipient does not have a contraindication to the requested agent

**AND**

4. For a non-preferred Intra-Articular Hyaluronate, the recipient has a documented history of therapeutic failure, contraindication or intolerance of the preferred Intra-Articular Hyaluronates

**OR**

5. The recipient does not meet the clinical review guidelines listed above, but, in the professional judgment of the physician

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reviewer, the services are medically necessary to meet the medical needs of the recipient.

FOR RENEWALS OF PRESCRIPTIONS FOR AN INTRA-ARTICULAR HYALURONATE - The determination of medical necessity of a request for prior authorization of a renewal of a prescription for an Intra-Articular Hyaluronate that was previously approved will take into account whether:

1. The recipient has documented improvement in pain or joint function following the first treatment

**AND**

2. It has been at least 6 months since the previous treatment if requested for a previously treated knee

**OR**

3. 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.

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 medical necessity of the request for a prescription for an Intra-Articular Hyaluronate. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are 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.

E. Dose and Duration of Therapy

The Department will limit authorization of prescriptions for Intra-Articular Hyaluronates as follows:

1. For an initial request - One treatment course limited to one knee

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2. For a renewal of a previously approved request - One treatment course per knee

References

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