pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
July 23, 2018	July 23, 2018	*See below

SUBJECT

Prior Authorization of Immunomodulators, Atopic Dermatitis – Pharmacy Services

BY

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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

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Immunomodulators, Atopic Dermatitis submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program and providing services in the fee-for-service delivery system. Providers rendering services under the MA managed care delivery system should address any questions related to Immunomodulators, Atopic Dermatitis to the appropriate managed care organization.

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

*01-18-13	09-18-14	27-18-12	33-18-13
02-18-08	11-18-08	30-18-08	
03-18-08	14-18-09	31-18-14	
08-18-15	24-18-09	32-18-08	

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

recommendations relating to the following:

- 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;
- Classes of drugs to be added to the PDL; and
- Guidelines to determine medical necessity.

DISCUSSION:

During the May 16, 2018, meeting, the P&T Committee recommended that Eucrisa (crisaborole), which was previously not reviewed, be designated as preferred, and recommended guidelines to determine medical necessity, and a provision for automated prior authorization. The Committee also recommended that Dupixent (dupilumab), originally included in the Cytokine and CAM Antagonists class of drugs, be included in this class and continue to be designated as non-preferred with no change to the medical necessity guidelines. The recommendations were subject to public review and comment, and subsequently approved for implementation by DHS with updated handbook pages that reflect these changes.

PROCEDURE:

The procedures for prescribers to request prior authorization of Immunomodulators, Atopic Dermatitis 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 Immunomodulators, Atopic Dermatitis) 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
Immunomodulators, Atopic Dermatitis

I. Requirements for Prior Authorization of Immunomodulators, Atopic Dermatitis

A. Prescriptions That Require Prior Authorization

Prescriptions for Immunomodulators, Atopic Dermatitis that meet the following conditions must be prior authorized.

1. A non-preferred Immunomodulator, Atopic Dermatitis. See Preferred Drug List (PDL) for the list of preferred Immunomodulators, Atopic Dermatitis at: https://papdl.com/preferred-drug-list.

2. A prescription for Eucrisa (crisaborole topical).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Immunomodulator, Atopic Dermatitis, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred topical calcineurin inhibitor, has a documented history of therapeutic failure, a contraindication to, or intolerance of the preferred topical calcineurin inhibitors

AND

2. For Dupixent (dupilumab),

   a. Is prescribed Dupixent (dupilumab) for treatment of a condition that is a U.S. Food and Drug Administration (FDA) approved, or a medically accepted, indication

   AND

   b. Is prescribed a dose that is appropriate for the beneficiary's age, weight, concurrent medications, liver function, and renal function in accordance with the package labeling

   AND

   c. Is prescribed the Dupixent (dupilumab) by, or in consultation with, a specialist (i.e. dermatologist, immunologist, etc.)

   AND

d. For treatment of chronic moderate to severe atopic dermatitis,

i. Has a documented history of therapeutic failure, contraindication, or intolerance to the following topical pharmacologic treatments:

a) For treatment of the face or skin folds, low-potency topical corticosteroids

OR

b) For the treatment of areas other than the face or skin folds, medium- to high-potency topical corticosteroids

AND

c) Topical calcineurin inhibitors

AND

ii. Has a documented history of therapeutic failure, contraindication, or intolerance to phototherapy in accordance with current consensus guidelines

AND

iii. Has a history of therapeutic failure, contraindication, or intolerance to systemic immunosuppressives in accordance with current consensus guidelines (e.g, cyclosporine, azathioprine, methotrexate, mycophenolate mofetil)

OR

3. For Eucrisa (crisaborole topical):

a. Has a documented history of therapeutic failure, a contraindication to, or intolerance of a topical calcineurin inhibitor

AND

b. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature

NOTE: As described in Section C, if the beneficiary 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 beneficiary, the request for prior authorization will be approved.

C. 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 a prescription for an Immunomodulator, Atopic Dermatitis. 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 beneficiary.

D. Automated Prior Authorization Approvals

Prior authorization of a prescription for Eucrisa (crisaborole) will be automatically approved when the PROMISe Point-of-Sale On-Line Claims Adjudication System verifies a record of a paid claim(s) within 90 days of the date of service that documents that the guidelines to determine medical necessity listed in Section C have been met.