

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:
www.providersynergies.com/services/documents/PAM_PDL.pdf
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

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

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 Arcapta (indacaterol), whether the recipient:
 - a. Has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD)

AND

- b. Has a history of therapeutic failure, contraindication, or intolerance to:
 - i. Foradil (formoterol) **AND**
 - ii. Serevent (salmeterol)

AND

- c. Is not using any other long acting Beta 2 Agonist

AND

5. 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

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

6. 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 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.