pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
October 25, 2019	January 1, 2020	*See below

SUBJECT

Prior Authorization of Macrolides (Formerly Macrolides/Ketolides) – Pharmacy Services

BY

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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 Macrolides 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 in the MA managed care delivery system should address any questions related to Macrolides to the appropriate managed care organization.

BACKGROUND/DISCUSSION:

The Department of Human Services (Department) is changing the title of the Macrolides/Ketolides Preferred Drug List class of drugs to Macrolides to more accurately reflect the drugs included in this class. The Department is also updating the prior authorization

*01-19-74	09-19-70	27-19-68	33-19-70
02-19-68	11-19-67	30-19-66	
03-19-67	14-19-66	31-19-73	
08-19-76	24-19-68	32-19-66	

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

guidelines for Macrolides to clarify that a review for medical necessity of a non-preferred Macrolide will take into account the beneficiary's diagnosis. There are no other changes to the medical necessity guidelines.

PROCEDURE:

The procedures for prescribers to request prior authorization of Macrolides 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 chapter related to Macrolides) 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

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements
http://www.dhs.pa.gov/provider/pharmacyservices/pharmacypriorauthorizationgeneralrequirements/index.htm

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm

I. Requirements for Prior Authorization of Macrolides (formerly Macrolides/Ketolides)

A. Prescriptions That Require Prior Authorization

Prescriptions for a non-preferred Macrolide must be prior authorized.

See the Preferred Drug List (PDL) for the list of preferred Macrolides 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 a non-preferred Macrolide, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. **One** of the following:

    a. Has a history of therapeutic failure, contraindication, or intolerance to the preferred Macrolides approved or medically accepted for the beneficiary's diagnosis
    b. Has culture and sensitivity test results documenting that only non-preferred Macrolides will be effective.

    NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement 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 a non-preferred Macrolide. 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.