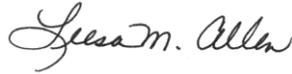


<b>ISSUE DATE</b> June 22, 2015	<b>EFFECTIVE DATE</b> July 20, 2015	<b>NUMBER</b> *See below
<b>SUBJECT</b> Prior Authorization of Antifungals, Topical – Pharmacy Service		<b>BY</b>  Leesa M. Allen, Deputy Secretary Office of Medical Assistance Programs

**PURPOSE:**

The purpose of this bulletin is to issue updated handbook pages that include instructions on how to request prior authorization of prescriptions for Antifungals, Topical, including the type of medical information needed to evaluate requests for medical necessity.

**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 (FFS) delivery system, including pharmacy services to residents of long term care facilities.

**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 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 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.

*01-15-17	09-15-17	27-15-14	
02-15-14	11-15-14	30-15-14	
03-15-14	14-15-14	31-15-17	
08-15-17	24-15-15	32-15-14	33-15-16

<p><b>COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:</b></p> <p>The appropriate toll free number for your provider type</p> <p>Visit the Office of Medical Assistance Programs Web site at <a href="http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/index.htm">http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/index.htm</a></p>
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**DISCUSSION:**

During the May 20, 2015 meeting, the P&T Committee recommended revisions to the guidelines to determine medical necessity of Antifungals, Topical to include two new agents in this class of drugs, Jublia (efinaconazole) and Kerydin (tavaborole). The updated guidelines to determine medical necessity were subject to public review and comment, and subsequently approved for implementation by the Department. The revised clinical review guidelines to determine the medical necessity of Antifungals, Topical are included in the attached updated provider handbook pages.

**PROCEDURE:**

The procedures for prescribers to request prior authorization of Antifungals, Topical 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 Antifungals, Topical) 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  
Antifungals, Topical

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**I. Requirements for Prior Authorization of Topical Antifungals**

A. Prescriptions That Require Prior Authorization

A prescription for a non-preferred Topical Antifungal must be prior authorized. See Preferred Drug List (PDL) for the list of preferred Topical Antifungals at:

[www.providersynergies.com/services/documents/PAM\\_PDL.pdf](http://www.providersynergies.com/services/documents/PAM_PDL.pdf)

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Topical Antifungal, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For a solution for the treatment of onychomycosis, whether the recipient:

- a. Is age-appropriate according to package labeling

**AND**

- b. Has a diagnosis of onychomycosis that causes a medical problem and is confirmed by culture

**AND**

- c. Has a history of a contraindication, intolerance to, or therapeutic failure of oral Terbinafine and Itraconazole.

2. For all other non-preferred Topical Antifungals, whether the recipient has a history of a contraindication, intolerance to, or therapeutic failure of the preferred Topical Antifungals.

**OR**

3. 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. Clinical Review Process

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

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

assess the medical necessity of the request for a prescription for a non-preferred Topical Antifungal. If the guideline in Section B is met, the reviewer will prior authorize the prescription. If the 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.

References:

1. UpToDate – “Onychomycosis” accessed 04/24/15
2. Ciclopirox prescribing information.
3. Jublia prescribing information. Valeant Pharmaceuticals North America LLC. February 2015
4. Kerydin prescribing information. Anacor Pharmaceuticals, Inc. July 2014.