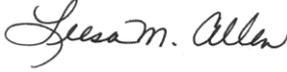




<b>ISSUE DATE</b> June 25, 2015	<b>EFFECTIVE DATE</b> July 20, 2015	<b>NUMBER</b> *See below
<b>SUBJECT</b> Prior Authorization of GI Motility, Chronic Agents (Formerly Irritable Bowel Syndrome Agents) - Pharmacy Service		<b>BY</b>  Leesa M. Allen, Deputy Secretary Office of Medical Assistance Programs

**PURPOSE:**

The purpose of this bulletin is to:

1. Inform providers that the Department of Human Services (Department) is changing the name of the Irritable Bowel Syndrome Agents class of drugs to GI Motility, Chronic Agents.
2. Issue handbook pages that include instructions on how to request prior authorization of prescriptions for GI Motility, Chronic Agents, 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 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.

*01-15-18	09-15-18	27-15-15	
02-15-15	11-15-15	30-15-15	
03-15-15	14-15-15	31-15-18	
08-15-18	24-15-16	32-15-15	33-15-17

**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.state.pa.us/provider/healthcaremedicalassistance/index.htm>

**DISCUSSION:**

During the May 20, 2015, meeting, the P&T Committee recommended revisions to the GI Motility, Chronic Agents handbook pages to reflect the change in the name of the class and revisions to the guidelines to determine medical necessity to recognize the addition of two new agents to the class, Movantik (naloxegol) and Relistor (methylnaltrexone bromide). The revised 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 GI Motility, Chronic Agents are included in the attached updated provider handbook pages.

**PROCEDURE:**

The procedures for prescribers to request prior authorization of GI Motility, Chronic Agents 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 GI Motility, Chronic Agents) 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  
GI Motility, Chronic Agents

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**Requirements for Prior Authorization of GI Motility, Chronic Agents  
(Formerly Irritable Bowel Syndrome Agents)**

A. Prescriptions That Require Prior Authorization

Prescriptions for GI Motility, Chronic Agents that meet any of the following conditions must be prior authorized:

1. A prescription for a preferred or non-preferred GI Motility, Chronic Agent regardless of the quantity prescribed. See the Preferred Drug List (PDL) for the list of preferred and non-preferred GI Motility, Chronic Agents at:  
[www.providersynergies.com/services/documents/PAM\\_PDL.pdf](http://www.providersynergies.com/services/documents/PAM_PDL.pdf)
2. A prescription for a GI Motility, Chronic Agent with a prescribed quantity that exceeds the quantity limit. See Quantity Limits for the list of drugs with quantity limits at:  
<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/pharmacyservices/quantitylimitslist/index.htm>

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a GI Motility, Chronic Agent, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. Is being treated for a condition that is U.S. Food and Drug Administration (FDA) approved, or a medically accepted indication

**AND**

2. Does not have a contraindication to the prescribed GI Motility, Chronic agent

**AND**

3. Has a history of therapeutic failure, contraindication or intolerance to laxatives, fiber supplementation, osmotic agents, bulk forming agents, and glycerin or bisacodyl suppositories

**AND**

4. For a non-preferred GI Motility, Chronic Agent, has a history of therapeutic failure, contraindication or intolerance to the preferred GI Motility, Chronic Agents

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**AND**

5. In addition, if a prescription for either a preferred or non-preferred GI Motility, Chronic Agent is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter

**OR**

6. 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 assess the medical necessity of the request for a prescription for a GI Motility, Chronic Agent. 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.

References

1. Amitiza prescribing information, April 2013.
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3. World Gastroenterology Organization Global Guideline: Irritable bowel syndrome: a global perspective. 2009, April 20.
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5. Management of chronic constipation in adults. UpToDate, accessed May 6, 2015
6. Cancer pain management with opioids: Prevention and management of side effects. UpToDate, accessed May 6, 2015