pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
December 12, 2018	December 17, 2018	*See below

SUBJECT

Prior Authorization of Angiotensin Modulator Combinations – Pharmacy Services

BY

Sally A. Kozak, Deputy Secretary
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 Angiotensin Modulator Combinations 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 Angiotensin Modulator Combinations to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services' (DHS) Drug Utilization Review Board meets semi-annually to review provider prescribing and dispensing practices for efficacy, safety, and

*01-18-25	09-18-26	27-18-25	33-18-25
02-18-20	11-18-20	30-18-20	
03-18-21	14-18-21	31-18-26	
08-18-28	24-18-22	32-18-20	

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

quality and to recommend interventions for prescribers and pharmacists through the DHS Prospective Drug Use Review and Retrospective Drug Use Review programs.

DISCUSSION:

The Angiotensin Modulator Combinations Preferred Drug List (PDL) class no longer includes any Aliskiren-containing agents. DHS is updating the handbook pages to remove the medical necessity guidelines specific to aliskiren agents since they are no longer applicable to this PDL class. The proposed revisions to the guidelines to determine medical necessity were subject to public review and comment, and subsequently approved for implementation by DHS.

PROCEDURE:

The procedures for prescribers to request prior authorization of Angiotensin Modulator Combinations 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 Angiotensin Modulator Combinations) 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
Angiotensin Modulator Combinations

I. Requirements for Prior Authorization of Angiotensin Modulator Combinations

A. Prescriptions That Require Prior Authorization

Prescriptions for Angiotensin Modulator Combinations that meet any of the following conditions must be prior authorized:

1. A non-preferred Angiotensin Modulator Combination drug. See the Preferred Drug List (PDL) for the list of preferred Angiotensin Modulator Combinations at: https://papdl.com/preferred-drug-list.

2. An Angiotensin Modulator Combination drug with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm.

3. An Angiotensin Modulator Combination drug when there is a record of a recent paid claim for a Calcium Channel Blocker, ACE Inhibitor, Angiotensin Receptor Blocker (ARB), or another Angiotensin Modulator Combination in DHS' 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 non-preferred Angiotensin Modulator Combination drug, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For a non-preferred Angiotensin Modulator Combination drug, whether the beneficiary has a history of a contraindication, intolerance to, or therapeutic failure of the preferred Angiotensin Modulator Combination drugs

AND

2. For therapeutic duplication, whether:

   a. The beneficiary 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

AND

3. If a prescription for an Angiotensin Modulator Combination 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.

   NOTE: 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 Angiotensin Modulator Combination drug. 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. References

1. Amturnide package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. March 2012.
2. http://www.fda.gov/drugs/drugsafety/ucm300889.htm, accessed May 2012.
3. Tekamlo package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. March 2012.
4. Valturna package insert. Novartis Pharmaceuticals Corporation, East Hanover, NJ. April 2012.