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 Modulators – Pharmacy Services

BY

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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 Modulators 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 Modulators to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services' (DHS) Drug Utilization Review (DUR) Board meets semi-annually to review provider prescribing and dispensing practices for efficacy, safety, and quality and to recommend interventions for prescribers and pharmacists through the DHS

*01-18-26	09-18-27	27-18-26	33-18-26
02-18-21	11-18-21	30-18-21	
03-18-22	14-18-22	31-18-27	
08-18-29	24-18-23	32-18-21	

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

Prospective Drug Use Review and Retrospective Drug Use Review programs.

DISCUSSION:

During the September 25, 2018, DUR Board meeting, the DUR Board recommended that DHS update the medical necessity guidelines for Angiotensin Modulators to ensure safe and appropriate utilization of angiotensin receptor-neprilysin inhibitors and aliskiren agents. The proposed revisions to the guidelines to determine medical necessity, as recommended by the DUR Board, 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 Modulators 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 Modulators) 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 Modulators

I. Requirements for Prior Authorization of Angiotensin Modulators

A. Prescriptions That Require Prior Authorization

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

1. A non-preferred Angiotensin Modulator, including an Angiotensin Modulator in combination with HCTZ, regardless of the quantity prescribed. See the Preferred Drug List (PDL) for the list of preferred Angiotensin Modulators at: https://papdl.com/preferred-drug-list.

2. An Angiotensin Modulator 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 ACE Inhibitor when there is a record of a recent paid claim for another ACE Inhibitor, an Angiotensin Receptor Blocker (ARB), or an Angiotensin Modulator Combination in DHS' Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

4. An ARB when there is a record of a recent paid claim for another ARB, an ACE Inhibitor, or an Angiotensin Modulator Combination in DHS' Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

5. An angiotensin receptor-neprilysin inhibitor (ARNI).

B. Exemptions From Prior Authorization

The following are exempt from prior authorization:

1. Qbrelis (lisinopril oral solution) when prescribed for a child under 9 years of age.

2. Epaned (enalapril oral solution) when prescribed for a child under 6 years of age.

C. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Angiotensin Modulator, the determination of whether the

requested prescription is medically necessary will take into account the following:

1. For an initial request for approval of an Aliskiren Agent, whether the beneficiary:

   a. Is age-appropriate according to FDA-approved package labeling or nationally recognized compendia

      AND

   b. Has a documented diagnosis of uncontrolled hypertension despite treatment with the following drug classes at maximum tolerated Food and Drug Administration (FDA) approved doses unless contraindicated: Calcium Channel Blockers, Beta Blockers, Diuretics, ACE Inhibitors, and ARBs

      AND

   c. Is not taking an ACE Inhibitor or an ARB

   AND

2. For a request for a renewal of a prescription for an Aliskiren Agent, whether the beneficiary:

   a. Is not taking an ACE Inhibitor or an ARB

   AND

3. For an initial request for approval of an angiotensin receptor-neprilysin inhibitor (ARNI), whether the beneficiary:

   a. Is prescribed the requested ARNI for treatment of a condition that is a U.S. Food and Drug Administration (FDA) approved or a medically accepted indication

      AND

   b. Is prescribed the medication by or in consultation with a cardiologist

      AND

   c. Is age-appropriate according to FDA-approved package labeling or nationally recognized compendia

AND

d. Has no contraindication to the prescribed ARNI

AND

e. Does not have severe hepatic impairment

AND

f. Is prescribed a dose that is consistent with FDA-approved package labeling or nationally recognized compendia

AND

g. Has evidence of tolerability to an ACE inhibitor or an ARB

AND

h. Is currently receiving optimally tolerated doses of all of the following:

    i. Beta blocker (carvedilol, metoprolol succinate sustained release, bisoprolol)
    ii. Mineralocorticoid receptor blocker
    iii. Diuretic

OR

i. Has a contraindication or intolerance to optimally titrated doses of all of the following:

    i. Beta blocker (carvedilol, metoprolol succinate sustained release, bisoprolol)
    ii. Mineralocorticoid receptor blocker
    iii. Diuretic

AND

4. For a request for a renewal of a prescription for an ARNI, whether the beneficiary:

a. Is prescribed the medication by or in consultation with a cardiologist

AND

b. Has no contraindication to the prescribed ARNI

AND

c. Does not have severe hepatic impairment

AND

d. Is prescribed a dose that is consistent with FDA-approved package labeling or nationally recognized compendia

AND

5. For all other non-preferred Angiotensin Modulators, whether the beneficiary has a history of therapeutic failure or intolerance of the preferred Angiotensin Modulators

AND

6. For therapeutic duplication, whether:

a. For an ACE Inhibitor, the beneficiary is being titrated to, or tapered from, another ACE Inhibitor, an ARB, or an Angiotensin Modulator Combination

AND

b. For an ARB, the beneficiary is being titrated to, or tapered from, another ARB, an ACE Inhibitor, or an Angiotensin Modulator Combination

OR

c. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested

AND

7. If a prescription for an Angiotensin Modulator 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 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.

D. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section C. above to assess the medical necessity of a prescription for an Angiotensin Modulator. If the guidelines in Section C. 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.

E. References

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