Prior Authorization of Hypoglycemics, Incretin Mimetics/Enhancers – Pharmacy Services

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 Hypoglycemics, Incretin Mimetics/Enhancers submitted for prior authorization.

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 Hypoglycemics, Incretin Mimetics/Enhancers to the appropriate managed care organization.

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

*01-18-29  09-18-30  27-18-29  33-18-29  
02-18-24  11-18-24  30-18-24  
08-18-32  24-18-26  32-18-24

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:**

During the September 25, 2018, DUR Board meeting, the DUR Board recommended removing multiple elements from the medical necessity guidelines for Hypoglycemics, Incretin Mimetics/Enhancers based on the recommendations of multiple national treatment guidelines to individualize drug therapy and the lack of compelling medical literature and guidelines that definitively support the use of specific classes of hypoglycemics as second-line choices. The DUR Board also recommended automating prior authorization of preferred Hypoglycemics, Incretin Mimetics/Enhancers (except for amylin analogs). 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 Hypoglycemics, Incretin Mimetics/Enhancers 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 Hypoglycemics, Incretin Mimetics/Enhancers) 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
Hypoglycemics, Incretin Mimetics/Enhancers
I. **Requirements for Prior Authorization of Hypoglycemics, Incretin Mimetics/Enhancers**

A. **Prescriptions That Require Prior Authorization**

   All prescriptions for Hypoglycemics, Incretin Mimetics/Enhancers must be prior authorized.

   1. See the Preferred Drug List (PDL) for the list of preferred and non-preferred Hypoglycemics, Incretin Mimetics/Enhancers at: [https://papdl.com/preferred-drug-list](https://papdl.com/preferred-drug-list).

   2. 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](http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).

B. **Review of Documentation for Medical Necessity**

   In evaluating a request for prior authorization of a prescription for a Hypoglycemics, Incretin Mimetic/Enhancer, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

   1. For a glucagon-like peptide-1 (GLP-1) receptor agonist or dipeptidyl peptidase-4 (DPP-4) inhibitor:

      a. Has a diagnosis of type 2 diabetes mellitus

      AND

      b. Has a documented history of:

         i. Failure to achieve glycemic control as evidenced by the beneficiary’s HbA1c values using maximum tolerated doses of metformin

         OR

         ii. A contraindication or intolerance to metformin

      AND

   2. For an amylin analog:

      a. Has a diagnosis of type 1 diabetes mellitus
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OR

b. Has a diagnosis of type 2 diabetes mellitus and has a documented history of:

i. Failure to achieve glycemic control as evidenced by the beneficiary’s HbA1c values using maximum tolerated doses of metformin

OR

ii. A contraindication or intolerance to metformin

AND

c. Failed to achieve adequate glycemic control as evidenced by the beneficiary’s HbA1c values despite compliance with optimal insulin therapy

AND

d. Will be prescribed the requested amylin analog in combination with insulin

AND

3. For a non-preferred Hypoglycemics, Incretin Mimetic/Enhancer, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Hypoglycemics, Incretin Mimetics/Enhancers with the same mechanism of action

AND

4. If a prescription for a Hypoglycemics, Incretin Mimetic/Enhancer 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.

December 17, 2018
(Replacing October 3, 2016)
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FOR RENEWALS OF PRESCRIPTIONS FOR AN AMYLIN ANALOG:
Requests for prior authorization of renewals of prescriptions for an amylin analog that were previously approved will take into account whether the beneficiary:

1. Has improved glycemic control as evidenced by a recent HbA1c value

AND

2. If a prescription for an amylin analog 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. Automated Prior Authorization

Prior authorization of a prescription for a preferred Hypoglycemics, Incretin Mimetic/Enhancer (except for an amylin analog) with a prescribed quantity that does not exceed the quantity limit will be automatically approved when the Point-of-Sale On-Line Claims Adjudication System verifies a record of a paid claim(s) within 90 days of the date of service that documents that the guidelines to determine medical necessity listed in Section B. have been met.

D. 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 Hypoglycemics, Incretin Mimetic/Enhancer. If the applicable guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the applicable 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


