

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Antibiotics, Vaginal

A. Prescriptions That Require Prior Authorization

All prescriptions for non-preferred Antibiotics, Vaginal must be prior authorized. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Antibiotics, Vaginal.

B. Review of Documentation for Medical Necessity

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

1. Whether the recipient has a documented history of therapeutic failure or intolerance of the preferred Antibiotics, Vaginal;

OR

2. Whether the recipient does not meet the clinical review guidelines listed in B.1. 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 guidelines in Section B. 1. above, to assess the medical necessity of the request for a prescription for a non-preferred Antibiotic, Vaginal. If either of the guidelines in Section B 1. is met, the reviewer will prior authorize the prescription. If neither of the guidelines is 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.