pennsylvania
DEPARTMENT OF PUBLIC WELFARE

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
July 14, 2011	August 8, 2011	*See Below

SUBJECT	BY
Incretin Memetic/Enhancer Hypoglycemics Handbook Pages - Pharmacy Services	Izanne Leonard-Haak, Acting Deputy Secretary Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to issue updated Prior Authorization of Pharmaceutical Services Handbook pages for Incretin Memetic/Enhancer Hypoglycemics that include instructions on how to request prior authorization of prescriptions that require prior authorization, 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 of Public Welfare's (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 new 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.

*01-11-33	09-11-34	27-11-31
02-11-28	11-11-28	30-11-28
03-11-29	14-11-29	31-11-34
08-11-35	24-11-32	32-11-28

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

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DISCUSSION:

During the May 5, 2011 P&T Committee meeting, the P&T Committee reviewed the Incretin Mimetic/Enhancer Hypoglycemics class of drugs. As a result of that review, the guidelines to determine medical necessity were revised as follows:

1. Added guidelines to determine medical necessity of Kombiglyze XR;
2. Added a general guideline for trial and failure, contraindication, or intolerance of preferred Incretin Mimetic/Enhancer Hypoglycemics to determine medical necessity of non-preferred Incretin Mimetic/Enhancer Hypoglycemics.

PROCEDURE:

The procedures for prescribers to request prior authorization of non-preferred drugs, preferred drugs that require prior authorization, and drugs not subject to the PDL that require prior authorization and for pharmacies to dispense an emergency supply of medication when necessary and without prior authorization 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 specific therapeutic classes of drugs) in reviewing the prior authorization request to determine medical necessity.

The requirements for prior authorization and clinical review guidelines to determine medical necessity of Incretin Mimetic/Enhancer Hypoglycemics are included in the attached updated provider handbook pages.

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

Incretin Mimetic/Enhancer Hypoglycemics