I. Requirements for Prior Authorization of Oral Fluoroquinolones

A. Prescriptions That Require Prior Authorization

Prescriptions for non-preferred Oral Fluoroquinolones must be prior authorized.
See Preferred Drug List (PDL) for the list of preferred Oral Fluoroquinolones at:
http://www.providersynergies.com/services/documents/PAM_PDL_20100223.pdf

B. Review of Documentation for Medical Necessity

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

1. Whether the recipient has a history of therapeutic failure, intolerance, or contraindication to alternative antibiotics

   OR

2. Whether the culture and sensitivity test results document that only non-preferred Oral Fluoroquinolones will be effective

   OR

3. Whether the recipient 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 recipient.

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 the request for a prescription for a non-preferred Oral Fluoroquinolone. If either of the guidelines in Section B. is met, the reviewer will prior authorize the prescription. If none of the guidelines are 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.