I. Requirements for Prior Authorization of Macrolides/Ketolides

A. Prescriptions That Require Prior Authorization

Prescriptions for non-preferred Macrolides/Ketolides must be prior authorized. See Preferred Drug List (PDL) for the list of preferred Macrolides/Ketolides 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 Macrolide/Ketolide, 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, intolerance, or contraindication to alternative antibiotics

OR

2. Whether culture and sensitivity test results document that only non-preferred Macrolides/Ketolides 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 Macrolide/Ketolide. If the guideline in Section B is met, the reviewer will prior authorize the prescription. If the guideline is 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 recipient.