

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Oral Anticonvulsants

A. Prescriptions That Require Prior Authorization

Prescriptions for Oral Anticonvulsants that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Oral Anticonvulsant. See the most recent version of the PDL which includes the list of preferred Oral Anticonvulsants at <http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/DoingBusiness/MAPharmProg/>
2. A prescription for Lyrica or Topamax, regardless of the quantity prescribed. See Quantity Limits which lists drugs with quantity limits at <http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/DoingBusiness/MAPharmProg/003675066.htm>

GRANDFATHER PROVISION: The Department will grandfather prescriptions for non-preferred Oral Anticonvulsants for those recipients currently being prescribed the same non-preferred Oral Anticonvulsant if the PROMISE Point-Of-Sale On-Line Claims Adjudication System verifies the record of payment by the Department for a prescription for the same non-preferred Oral Anticonvulsant within 90 days from the date of service of the new claim. If the recipient has a record of a prescription for the same non-preferred Oral Anticonvulsant, a prescription or a refill for the non-preferred Oral Anticonvulsant will be automatically approved.

B. Review of Documentation for Medical Necessity

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

1. For Lyrica, whether the recipient has one of the following:
 - a. A diagnosis of seizure disorders **OR**
 - b. A diagnosis of postherpetic neuralgia or diabetic neuropathy

AND

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- c. A history of therapeutic failure or intolerance of Gabapentin (at least 1800mg/day)
2. For Topamax, whether the recipient has a history of:
- a. A diagnosis of seizure disorder **OR**
 - b. A history of migraine headache defined as follows:
 - i. More than one (1) severe migraine attack per month that fails to respond adequately to symptomatic therapy and lifestyle changes

OR

 - ii. Two (2) or more headaches per week or more than eight (8) days per month that respond to abortive therapy
- OR**
- iii. Less frequent but protracted migraine attacks which impair quality of life (e.g., two [2] or more migraines per month with disability lasting three [3] or more days per month)
- OR**
- iv. Contraindication to, overuse of, intolerable side effects from, or poor response to symptomatic/abortive medications
- OR**
- v. Presence of uncommon migraine conditions (e.g., prolonged aura greater than one (1) hour, hemiplegic migraine, or migraine-induced stroke)

AND

- c. Therapeutic failure of any two (2) of the first line preventive therapies for migraine headache, as delineated by the American Academy of Neurology, within medically accepted therapeutic dose ranges (as listed in the package insert, drug compendia, or peer-

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reviewed medical literature) for at least a one (1) month trial each.

NOTE: Future revisions to the American Academy of Neurology Evidence-based Guidelines For Migraine Headache will apply when determining medical necessity.

See the American Academy of Neurology's Evidence-based Guidelines for Migraine Headache at:
<http://www.neurology.org/cgi/reprint/55/6/754.pdf>

3. For all other non-preferred Oral Anticonvulsants, whether the recipient has a history of therapeutic failure of at least four (4) preferred Oral Anticonvulsants; therapeutic failure of at least four (4) preferred Oral Anticonvulsants must include the generic equivalent when the generic equivalent is designated as preferred
4. In addition, if a prescription for either a preferred or non-preferred Oral Anticonvulsant 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.
5. For either a preferred or non-preferred Oral Anticonvulsant that does not meet the clinical review guidelines listed above, or a prescription for Topamax, the request 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.

C. Automated Prior Authorization Approvals

Prior authorization of a prescription for a non-preferred Oral Anticonvulsant at or below the quantity limits will be automatically approved when the PROMISE Point-Of-Sale On-Line Claims Adjudication System verifies a record of paid claim(s) within 90 days prior to the date of service that documents that the guidelines to determine medical necessity listed in Section B. have been met.

D. Clinical Review Process

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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 preferred or non-preferred Oral Anticonvulsant. If the guidelines in Section B are met and the prescription is not for Topamax, the reviewer will prior authorize the prescription. If the guidelines are not met, or if the prescription is for Topamax, 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.

References:

1. Lyrica[package insert]. New York, NY: [Pfizer Inc](http://www.pfizer.com); June 2007. <http://www.pfizer.com>
2. <http://www.nfra.net/Diagnost.htm>
3. Kaniecki R, Lucas S. Treatment of primary headache: preventive treatment of migraine. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache foundation; 2004. p. 40-52 (Includes US Headache Consortium Guidelines for Migraine Prophylaxis)
4. American Academy of Neurology. Practice parameter: Practice parameter: Evidence-based Guidelines for Migraine Headache (An Evidence-based Review) Report of the Quality Standards Subcommittee of the American Academy of Neurology, Neurology 2000;55;754-762.