

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Antibiotics, GI

A. Prescriptions That Require Prior Authorization

Prescriptions for Antibiotics, GI that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Antibiotic, GI. See Preferred Drug List (PDL) for the list of preferred Antibiotics, GI at: www.providersynergies.com/services/documents/PAM_PDL.pdf
2. A prescription for an Antibiotic, GI with a prescribed quantity that exceeds the quantity limit. See Quantity Limits for the list of drugs with quantity limits at: <http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>

B. Review of Documentation for Medical Necessity

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

1. For Flagyl ER, whether the recipient has a history of:
 - a. Therapeutic failure of preferred oral metronidazole or intravaginal gel (if applicable)

OR

 - b. A contraindication to or intolerance of preferred metronidazole
2. For Xifaxan, whether the recipient has:
 - a. A documented history of:
 - i. Therapeutic failure of at least one fluoroquinolone

OR

 - ii. A contraindication to or intolerance of fluoroquinolone therapy

OR

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b. A diagnosis of hepatic encephalopathy

AND

c. A documented history of therapeutic failure, contraindication or intolerance to lactulose

3. For all other non-preferred GI Antibiotics, whether the recipient has a history of therapeutic failure, contraindication or intolerance of the preferred GI Antibiotics.
4. For a prescription for an Antibiotic, GI 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.

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 an Antibiotic, GI. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are 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.

D. Automated Prior Authorization

Prior authorization of a prescription for Xifaxan 550 mg, with a prescribed quantity that does not exceed the quantity limit established by the Department, 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 above have been met

References

1. CDC Sexually Transmitted Diseases Treatment Guidelines 2006. Available at: <http://www.cdc.gov/std/treatment/2006/vaginal-discharge.htm#vagdis2>. Accessed on February 13, 2008.
2. Flagyl ER [package insert]. New York, NY; Pfizer; August 2006.

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3. Hill DR, Ericsson CD, Pearson RD, et al. The practice of travel medicine: guidelines by the Infectious Diseases Society of America. [Clin Infect Dis 2006;43:1499-539](#)
4. Centers for Disease Control and Prevention, Div. of Bacterial and Mycotic Diseases, Traveler's Diarrhea. Available at: www.cdc.gov/ncidod/dbmd/diseaseinfo/travelersdiarrhea_g.htm.
5. Xifaxan [package insert] Morrisville, NC; [Salix Pharmaceutical, Inc.](#) Jan. 2007.
6. Blei AT., Cordoba J, Practice Guidelines: Hepatic Encephalopathy. Am J. Gastroenterology. 2001; 96(7): 1968-76.
<http://www.gi.org/physicians/guidelines/HepaticEncephalopathy.pdf>
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