

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Leukotriene Modifiers (formerly Leukotriene Receptor Antagonists)

A. Prescriptions That Require Prior Authorization

Prescriptions for Leukotriene Modifiers that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Leukotriene Modifier, regardless of the quantity prescribed. See Preferred Drug List (PDL) for the list of preferred Leukotriene Modifiers at: www.providersynergies.com/services/documents/PAM_PDL.pdf
2. A prescription for a preferred Leukotriene Modifier 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/ucmprd/groups/webcontent/documents/document/s_002077.pdf

EXEMPTION FROM PRIOR AUTHORIZATION: Montelukast pediatric granules are exempt from prior authorization when prescribed for a child under 2 years of age

B. Clinical Review Guidelines and Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Leukotriene Modifier, the determination of whether the prescription is medically necessary will take into account whether the recipient:

1. Has a documented history of therapeutic failure, intolerance, or contraindication of the preferred Leukotriene Modifiers.

OR

2. Does not meet the clinical review guidelines above, but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.
3. In addition, if a prescription for a Leukotriene Modifier 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.

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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 Leukotriene Modifier. 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