

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Neuropathic Pain Agents (Formerly Myalgia and Neuropathy Agents)

A. Prescriptions That Require Prior Authorization

Prescriptions for Neuropathic Pain Agents that meet any of the following conditions must be prior authorized:

1. All prescriptions for non-preferred Neuropathic Pain Agents, regardless of the quantity prescribed. See the most recent Preferred Drug List (PDL) for the list of preferred and non-preferred Neuropathic Pain Agents at:
www.providersynergies.com/services/documents/PAM_PDL.pdf
2. All prescriptions for preferred Neuropathic Pain Agents medically accepted for the treatment of fibromyalgia, regardless of the quantity prescribed.
3. A prescription for a Neuropathic Pain Agent 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

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Neuropathic Pain Agent, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For requests for prior authorization of a preferred Neuropathic Pain Agent medically accepted for the treatment of fibromyalgia, whether the recipient has:
 - a. A diagnosis of fibromyalgia

AND

- b. A documented history of widespread pain as defined by the American College of Rheumatology present for at least three (3) months.

AND

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- c. A presence of 11 out of 18 paired, bilateral tender points as delineated by the American College of Rheumatology; see <http://www.nfra.net/Diagnost.htm> for a picture and description of the locations of tenderness

NOTE: Future final revisions to the American College of Rheumatology criteria for the classification of Fibromyalgia will apply when determining medical necessity. See the American College of Rheumatology website at <http://www.rheumatology.org/practice/clinical/classification/fibromyalgia/fibro.asp>

AND

- d. Been evaluated and treated for other causes of pain consistent with a differential diagnosis to include but not limited to the following:
- i. Rheumatic diseases
 - ii. Polymyalgia rheumatica
 - iii. Myositis
 - iv. Hypothyroidism
 - v. Neuropathies
 - vi. Hypovitaminosis D
 - vii. Liver disease

AND

- e. A history of therapeutic failure of, or a documented contraindication to, the following first line therapies:
- i. Non-pharmacologic therapies (Examples of non-pharmacologic therapies include, but are not limited to the following: heated pool treatment [with or without exercise], physiotherapy, cognitive-behavioral therapy, aerobic exercise, strength training, or relaxation, etc.),

AND

- ii. At least 1 pharmacological treatment from the following therapeutic classes or medications: tricyclic antidepressants, selective serotonin reuptake inhibitors, or gabapentin

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2. For requests for prior authorization of a non-preferred Neuropathic Pain Agent medically accepted for the treatment of fibromyalgia, whether the recipient:
 - a. Meets the guidelines listed above for a preferred Neuropathic Pain Agent

AND

- b. Has a documented history of therapeutic failure, contraindication or intolerance to the preferred Neuropathic Pain Agents

OR

3. For Gralise (gabapentin extended release) whether the recipient:
 - a. Has a diagnosis of postherpetic neuralgia (PHN)

AND

- b. Has a documented history of therapeutic failure, contraindication or intolerance to tricyclic antidepressants and regular release gabapentin (titrated to maximal tolerated effective dose of 1800 mg/day)

AND

- c. Does not have a creatinine clearance less than 30 mL/min

OR

4. For Lidoderm (lidocaine topical patch) whether the recipient:
 - a. Has a diagnosis of postherpetic neuralgia (PHN)

AND

- b. Has a documented history of therapeutic failure, contraindication or intolerance to tricyclic antidepressants

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and gabapentin (titrated to maximal tolerated effective dose of 1800 mg/day)

5. For Horizant (gabapentin enacarbill), whether the recipient is being prescribed a dose of the requested medication that is appropriate for his/her renal function according to package labeling AND;
 - a. Has a diagnosis of postherpetic neuralgia (PHN)

AND
 - b. Has a documented history of therapeutic failure, intolerance, or contraindication to tricyclic antidepressants and therapeutic failure or intolerance to regular release gabapentin (titrated to maximal tolerated effective dose of 1800 mg/day)

OR

- c. Has a diagnosis of moderate-to-severe primary Restless Leg Syndrome (RLS)

AND
- d. Has a documented history of therapeutic failure or intolerance to regular release gabapentin (titrated to maximal tolerated effective dose of 1800 mg/day) and therapeutic failure, contraindication or intolerance to pramipexole or ropinerole
6. For all other non-preferred Neuropathic Pain Agents, whether the recipient has a documented history of therapeutic failure, contraindication or intolerance to the preferred Neuropathic Pain Agents with the same indication

OR

7. For requests for prior authorization of either a preferred or non-preferred Neuropathic Pain Agent, 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.
8. In addition, if a prescription for either a preferred or non-preferred Neuropathic Pain Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines that are set forth in the Quantity Limits Chapter.

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9. For requests for renewals of prior authorization of either a preferred or non-preferred Neuropathic Pain Agent, whether the MA recipient has a documented clinical response showing symptom improvement or stabilization

C. Clinical Review Process

All requests for prior authorization of a Neuropathic Pain Agent will be automatically forwarded to a physician reviewer for a medical necessity determination.

The physician reviewer will prior authorize the prescription when:

1. The guidelines in Section B. are met, **OR**
2. In the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

References:

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