

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Oncology Agents, Breast Cancer

A. Prescriptions That Require Prior Authorization

Prescriptions for Oncology Agents, Breast Cancer that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Oncology Agent, Breast Cancer, regardless of the quantity prescribed. See Preferred Drug List (PDL) for the list of preferred Oncology Agents, Breast Cancer at:
www.providersynergies.com/services/documents/PAM_PDL.pdf
2. A prescription for a preferred Oncology Agent, Breast Cancer 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

GRANDFATHER PROVISION – The Department will grandfather prescriptions for Fareston (toremifene) when the PROMISe Point-Of-Sale On-Line Claims Adjudication System verifies that the recipient has a record of a paid claim for Fareston within the past 90 days from the date of service of the new claim. If the recipient has a record of a paid claim for Fareston, a prescription or a refill for Fareston will be automatically approved.

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

In evaluating a request for prior authorization of a prescription for a non-preferred Oncology Agent, Breast Cancer, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. Has a history of therapeutic failure, contraindication or intolerance to the preferred Oncology Agents, Breast Cancer

OR

2. 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.

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3. In addition, if a prescription for either a preferred or non-preferred Oncology Agent, Breast Cancer 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.

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 Oncology Agent, Breast Cancer. 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.